Questions from actuarial-bids@cms.hhs.gov for OACT User Group Call (UGC)

#	Topic	UGC date	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
1	Technical	4/20/2006	4/12/2006 4:23 PM	BPT Question	In the past, we were able to unprotect the BPT so that we could integrate some of the tabs and formula's into our internal pricing model. This allows us to model many different scenarios during our planning process. This year, it appears that the BPT is very much locked down. While I understand that you do not want versions of the BPT altered that will be used for uploading, are you willing to provide us with an unlocked version that we could use with our internal pricing model. It would save us a lot of time and effort during this narrow planning window that we have. In summary, I am asking if you can send me an unprotected version of the 2007 BPT. I promise that it will be in no way used in association with any upload or any final versions that we send to CMS. This would be an tremendous help to us.	Consistent with other HPMS security requirements, OACT cannot release the BPT password. The technical instructions contain guidance on linking the BPT to other files/models. If you have any technical difficulties working with the protected BPT, please contact the HPMS Help Desk.
2	Technical	4/20/2006	4/19/2006 1:57 PM	What is the password for the 2007 BPT? That is another change made on the BPT.	<None>	See response to #1 regarding the BPT password and security.
3	Part D	4/20/2006	4/10/2006 1:51 PM	Special Needs Plans	Is a SNP covering dual eligible beneficiaries permitted to offer an MA/PDP plan with a Supplemental Part D benefit that waives the nominal copays (Ex: $1/$3 copays, $2/$5 copays, etc.). If this is permitted, is the plan permitted to use Part C rebates to subsidize any premiums related to the Supplemental Part D premium with the goal of a $0 Part D supplemental premium. This would be integrated with a target Part D basic premium equal to the low income premiums subsidy.	There is no ability to to waive copays. Plans could set up an Enhanced Alternative plan with $0 cost sharing, but this would eliminate all Low-Income Subsidy payments.
4	Part D	4/20/2006	4/14/2006 12:13 PM	Part D Risk Sharing Questions	We have a question about the Part D risk sharing calculation: When calculating the target amount, there is an "administration cost percentage" that is applied to direct subsidy payments and total beneficiary premiums. In the 2006 Advance Notice (2/18/05), there is a description of the target amount calculation on page 51 but it does not specifiy what should be included in the administration cost percentage. In the PDE Instructions, the administrative cost ratio is defined as (Total Non-Pharmacy Expense + Gain/Loss)/Total Basic Bid on page 51. Is this the correct definition (i.e. is our assumed profit to also be subtracted from revenues when calculating the target amount)? Is there other documentation that describes this calculation?	The CY2007 PD BPT contains a field that explicitly contains the factor to be used in the target. This cell is F29 in Worksheet 7.
5	Part D	4/20/2006	4/14/2006 12:16 PM	Part D Risk Sharing Question	We have a question about the Part D risk sharing calculation: [ORGANIZATION NAME] has acquired another MA-PD health plan effective 4/1/06. How will the risk sharing be handled by CMS in this situation at the end of the payment year? Will a separate risk sharing calculation be performed for each carrier (adjusted for seasonality of claim payments) or will there be a combined settlement that will need to split between the health plans?	The risk sharing is at the plan level, so there would be multiple year end reconciliations.

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6	Part D	4/20/2006	4/14/2006 2:25 PM	Question about Bid Pricing Tool Error	I get a red circle error on Worksheet 6 (Script Projection) Cell H44. Last year, all of our bids had this OON Cost Sharing Field as 0, but this year it seems like the validation checks that this number is greater than 0. Is it necessary for this field to be 0 in order to submit the bids?	The validation error appears when the scripts, allowed costs and cost sharing are all zero. The validation does not recognize that 25% of zero equals zero. If Defined Standard cost sharing does not equal 25%, then the validation should apply. In the case of all zeroes (as described here) , the validation error can be ignored.
7	Part D	4/20/2006	4/17/2006 5:22 PM	2007 PDP Bid	I have some questions concerning the benefit design of our 2007 PDP bid. On page 10 of the call letter it states: "In general, we expect that more than two bids form a sponsoring organization would not provide meaningful variation, unless one of the bids is an enhanced alternative plan that provides coverage in the coverage gap." Does this imply, A). We can offer only one "non-enhanced" plan (defined standard, actuarially equivalent, or basic alternative), and possibly more than one "enhanced" plan as long as one provides coverage in the gap -or- B). We can offer more than one "non-enhanced" plan, as long there are meaningful differences (e.g. deductible vs no deductible, etc.) between the "non-enhanced" plans. For example, we could offer a defined standard and a basic alternative plan. If this is the case, is there any situation in which the two "non-enhanced" plans would not have the same bid as far as the resulting premiums, etc.	This question is better suited for the user calls hosted by staff from CMS Centers for Beneficiary Choices (CBC). OACT cannot address this question.
8	Part D	4/20/2006	4/17/2006 11:33 PM	Risk scoring and payment for Rx in 2007	Will there be a FFS normalization adjustment made to Rx risk scores and payments in 2007? If so, plans need to know in order to appropriately consider this in their bids.	No, the CY2007 Rx model is the same as CY2006.
9	MA	4/20/2006	4/10/2006 4:24 PM	2-Year Look-Back Form	For the 2006 bid cycle, our MSHO demonstration plan was not required to complete the 2-Year Look-Back Form. Will this be true for the 2007 bid cycle as well?	Plans with CY2005 Medicare experience must complete the Two-Year-Lookback-Form. Even plans that did not submit a CY2005 ACR must complete the 2YRLB form.
10	MA	4/20/2006	4/17/2006 9:00 AM	2007 MA BPT	Worksheet 1, Cell E16, Paid through date. The note for this cell states that paid through date must be greater than the incurred date and less then today's date. However, the cell will not validate if the paid through date is equal to Cell E15, the incurred to end date. CMS instructions for Worksheet 1, Section 2, Line 1 state that runout is expected but it doesn't say runout is required. Therefore, Cell E16 should take a date that is greater than or equal to Cell 15. Worksheet 6, Cell M27, Maximum value for Part B buydown. The cell returns a validation error "The Part B Buydown Rebate must be rounded to one decimal" no matter what is input in Cell R13, the user entry for the Part B Buydown. Therefore, the BPT never validates, even if zero, a blank, or any number even a rounded number is input.	W1 cell E16: The validation error occurs because the 'paid through date' and 'incurred to date' are not expected to be the same date. Consistent with the bid instructions, we expect that the base period data would include a reasonable amount of runout. If the dates are equal (i.e., no runout), the plan may be asked to justify their assumptions. W6 cell M27: The validation error on this cell contains a rounding error. The red-circle validation error on M27 should be ignored.

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11	MA	4/20/2006	4/18/2006 9:05 AM	MA BPT	In worksheet 6, cells L28 and L29 reference the rounded Part D values from R36 and R42. This makes it impossible to balance your rebates if you buy down all of your A/B Mandatory Supplemental benefits. We would recommend referencing the unrounded cells in R35 and R41 instead.	The Part D premium is rounded to one decimal in the Rx BPT, therefore the rebate allocations to Part D in the MA BPT must be rounded to one decimal. If there are pennies unallocated for rebates, the plan can slightly adjust their MA margin to fully allocate rebates.
12	MA	4/20/2006	4/18/2006 11:52 AM	OTC and Part C	When is CMS going to issue guidance on whether or not OTC Rx may be a supplemental benefit in Part C? This issue was mentioned last year and it was mentioned again in the 2007 Call Letter	This question is better suited for the user calls hosted by staff from CMS Centers for Beneficiary Choices (CBC). OACT cannot address this question. UPDATE 5/23/06: Clarification/further guidance was posted on HPMS earlier this month in the Weekly Bulletin dated 5/8/06 in a memo dated May 1, 2006.
13	MA	4/20/2006	4/17/2006 11:39 PM	Revenue basis in bids	The instructions clearly identify early 2006 as the preferred basis for identifying revenue for 2007 bids. Will there be flexibility permitted in this to allow use of 2005 claims vs exposure, in order to more clearly meet the ASOP requirement of matching the revenue base to the claims base? This is particularly needed when there are issues with early 2006 MMR's, and plans can't wait for the later MMR's to be produced and evaluated.	Updated guidance on the development of the 2007 MA bid risk scores is reflected in revised bid pricing tool instructions, which were posted on HPMS on April 27, 2006. This revised guidance will also be included in the May 5, 2006 HPMS Weekly Bulletin.
14	MA	4/20/2006	4/18/2006 10:46 AM	Bid Conference Follow Up Question	I attended the April 11th CMS bid conference. A question was asked regarding the need to submit experience data that would not be deemed credible and would not be used in the bid calculations. I did not receive clear indication that a definitive answer was given. We have several clients who entered the Medicare market in late 2005 and have a couple of months of data for a few hundred members. It will take some effort to compile this data which will not have an impact on the bid calculations. Has CMS reached a conclusion on this requirement?	OACT is considering adopting the following guideline. MA worksheet 1 is to be completed if the plan's base period data is at least 25% credible, or 1,500 member months, based on CMS credibility guidelines. If Worksheet 1 is not completed and the plan meets this credibility threshold, then the plan actuary may be asked to justify why the data was not used in the development of the bid. Plan actuaries can use the text field on Worksheet 1 Section II line 6 to provide an explanation of why the data was not used.
15	MA	4/20/2006	4/11/2006 3:56 PM	Worksheet 1 - MAPD Base Period Experience	Our plan is a new MAPD organization with 3 plans under one H#. We have 9 months of experience in CY 2005 and relatively low membership. One plan is new in 2006, but the other two were crosswalked from 2005. The member months over 9 months in 2005 for these two plans was 7433 and 3263 respectively. Based on this low membership should we load this experience + some 2006 data in Worksheet 1 of the MA BPT and apply a low credibility % or leave this worksheet blank and use a 100% manual rate?	See response to #14 regarding completing Worksheet 1 with base period data.
1	Both MA and PD	4/27/2006	4/25/2006 10:59 AM	Q&A	If a contractor intends to offer a PFFS-PD plan in a 30-state service area (a single benefit plan), please confirm that the PFFS-PD would be filed as a single bid (despite the fact that it covers several MA regions, it is still considered a local plan and therefore regional boundaries have no bearing on the bid process).	Local MA plans are to submit a single bid, despite spanning multiple Part D regions or states.

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#	Topic	UGC date	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
2	Part D	4/27/2006	4/20/2006 11:11 AM	Mail Order benefit	My question is regarding the Mail Order benefit. We offer Mail order benefit but our current manual rate does not have any mail order experience. My question is: Can we just make a top side adjustment to the cost assuming certain mail order utilization or do we need to explicitly fill out the bid form with Mail order cost & utilization details?	The PD BPT must be filled out with Mail Order cost and utilization details. As with other aspects of bidding, these estimates must be based on reasonable actuarial techniques.
3	MA-duals	4/27/2006	4/20/2006 12:31 PM	Weekly Actuarial Call - Dual Eligible	At the bid conference, I recall that Rich C. said additional guidance on Duals would be given in the first weekly actuarial call. My recollection was the issue of how to do the bid forms, as well as PBP simplification? I did not hear any today. Will this be coming in a future call?	The PBP structure is designed by CMS Centers for Beneficiary Choices (CBC). For completing the BPT, see the CY2007 Call Letter.
4	MA-employer	4/27/2006	4/21/2006 12:35 PM	MA Group Bids	We are offering our Medicare group members both Deductible Plans ($500 to $1,000) as well as Non Deductible plans with copay & coinsurances. For group bidding are we to file both a minimum Deductible plan as well as a minimum Non Deductible plan ?	EGWPs have the flexibility to bid either way. Plans can file bids for both plans, or they can file one bid for the deductible plan (as a "base package") and customize the benefits to each group covered.
5	MA-employer	4/27/2006	4/24/2006 11:16 AM	Group PPO Bid Question	I have a question pertaining to the expectation for the Group PPO bid. In the MA call letter, on page 63, it says that plans will have the option of bidding on a "composite" benefit package. However, in looking at the MA BPT instructions on page 61, it states that "Each employer-only group bid must reflect the composite characteristics of the individuals.... assumptions include, but not limited to... benefit package.." In summary, do we have to base our Group MA bid upon an assumed composite benefit package or can we base upon FFS benefit provisions? I note that in page 60 of your BPT instructions you note that you require documentation upon assumed benefit improvements upon the Actuarial Equivalence customization option, and am inquiring how this fits into your interpretation?	EGWPs have the flexibility to bid either way - as a FFS "base package" or as a composite/average bid for all benefit groups. For actuarial equivalence, supporting documentation must be submitted in accordance with the bid instructions.
6	MA-employer	4/27/2006	4/20/2006 8:52 AM	Question: 800-series base plan benefits	Question on acceptable approaches to filing base group Bids. At the Bidders Conference it was explained that organizations may either take a composite benefit approach (composite of actual benefits sold to all plan sponsors) or file the Medicare A/B benefits as a "base" plan from which MAOs may sell richer benefit "buy ups" to group plan sponsors. Our organization would like to do the latter but we have a clarifying question: May we file a lean HMO-style base benefit plan that approximates the A/B benefits rather than the actual indemnity-style Medicare A/B benefits for this purpose? This is the way we have done this historically and we understand it to be a common industry practice. It is easier to file (BPT and PBP) - also the actual 2007 A/B benefits will not be known by 6/5.	See response to #5.

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7	MA-risk scores	4/27/2006	4/20/2006 1:11 PM	HICNO-Level New Model Risk Scores on May 06 MMR Enrollees	From today's conference call, risk scores under the New Model will be available on HPMS summarized by contract and PBP# for - enrollees on the May 06 MMR - using 2005 incurred diagoses submitted through 03/15/06 and - using fully updated CMS status information for 2005 (e.g., Originally Disabled, etc.). To be able to produce this information--which is great!--HICNO level risk scores must be produced. Can this HICNO-level, New-Model risk score data for May 06 MMR enrollees be made available to us? HPMS may not be the proper distribution medium, but the information itself would be extremely useful to us in preparing actuarially sound Bids. Without it, we will be forced to us old, lagged MMR-consistent, diagnoses to prorate the aggregate new score on HPMS by product using our enrollment system information, which has significantly different product splits from the MMRs.	CMS will provide the data at the appropriate level for bidding purposes (contract/PBP and by beneficiary category).
8	MA-risk scores	4/27/2006	4/21/2006 10:54 AM	Risk Scores	You mentioned that I can get an updated risk score on HPMS based on 2005 data. However, when I was on the HPMS site, the most recent time period is 2004. I believe that this information is what is currently used for the risk payments for 2006. Therefore, I do not know how to access the expected risk scores with the 2005 data that was mentioned on the April 20th conference call. How do I get that information?	CMS is currently preparing data based on 2005 data with May06 cohort of enrollees. This data will be provided via HPMS in a downloadable format.
1	Part D - payment demonstrati on	5/4/2006	4/25/2006 3:10 PM	Q&A	The PDP instructions include examples of the Part D payment demonstration. It appears from the table on page 9 and the example on page 10 that the Flexible Capitation option is an arbitrage opportunity since it offers the same benefits as the Enhanced Alternative but for a lower supplemental premium. Correct? Is there any instance where a plan would benefit financially by offering the Enhanced Alternative w/o the Flexible Capitation demonstration? Who pays the $20 difference between the Flexible Capitation and Enhanced Alternative models as shown on page 10? If the benefits are the same and the supplemental premium is less under the Flexible Capitation model, it seems that CMS must be picking up the difference. Please confirm.	The payment demonstration allows for capitated reinsurance payments for plans with Alternative coverage. When a plan that doesn't participate in the demonstration provides benefits that reduce member's cost-sharing, the amount of federal reinsurance payments would be reduced since TrOOP would be satisfied at a later point in time. In the same circumstance for a plan participating in the reinsurance demonstration, the reinsurance payment would be a capitated payment based on the level of expected reinsurance claims under the defined standard benefit. This capitation amount replaces the federal reinsurance amounts where the risk would be fully reflected in the federal payment. The change in supplemental premiums is funded by the expected increase in federal reinsurance payments for the demonstration plan relative to the plan that has not participated in the demo.

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#	Topic	UGC date	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
2	Part D - payment demonstration	5/4/2006	4/29/2006 2:44 PM	MA Rebate option	Based on what I've been able to find, the reinsurance payment demonstration instructions published last year on May 10, 2005 doesn't indicate you must include a $250 deductible in the benefit plan when using the MA Rebate option. However, the BPT instructions related to the reinsurance demo payment published on May 12, 2005 do indicate that MA rebate options must maintain the $250 deductible when using the MA Rebate option. I don't see where this year's BPT instructions for using the payment demo requires the benefit plan to include the $265 deductible. Is a benefit plan that uses the MA Rebate Option in 2007 required to keep the $265 deductible? If so, where is the guidance on that? I believe the May 10, 2005 instructions superseded the Federal Register, so I'm not sure where the guidance is. Maybe it's in the May 10, 2005 instructions, and I just can't find it!	The MA rebate payment demonstration requires that supplemental benefits must be in the form of benefits in the coverage gap. There is no opportunity to provide additional benefits. This precludes changing the plan deductible.
3	Part D	5/4/2006	4/25/2006 3:36 PM	Questions	A PDP question: We are looking at filing a closed/limited formulary for a specific plan. In worksheet 6, I want confirmation that both columns f:h and i:k should reflect that limited formulary. The differences between the two sets of columns in terms of total allowed and script distribution for an actuarially equivalent plan should only be caused by utilization shifting from benefit design differences, not from a change in formulary.	Yes, both sets of columns should reflect the formulary. The difference in the left set of columns and the right set of columns should reflect the impact of tiering and/or cost sharing.
4	Part D	5/4/2006	4/26/2006 4:59 PM	RE: Questions	A PDP question: When looking a member in the catastrophic coverage period what cost sharing is applied first - member, reinsurance or insurer? For example, if the member gets a brand $20 drug, if the 80% reinsurance is applied first, the reinsurance cost is $16, and then the member cost is the remainder $4 with the insurer having a cost of $0. Or is the brand copay applied first with coinsurance second? So the member having a $5.35 copay and the reinsurance paying the difference.	The order of cost sharing is: 1) member (at Point of Sale based on cost of Rx) 2) reinsurance (based on cost of Rx) 3) insurer (the balance remaining). In the example of a $20 generic drug, the beneficiary cost sharing would be $2 (assuming generic Rx), reinsurance pays 80% ($16), and plan obligation is the remaining $2.
5	Part D	5/4/2006	4/26/2006 3:03 PM	Questions for 04/27/2006 User's Group Call	(1) Does CMS know which month's membership the weighted 2007 Part D values (Natl Avg Bid, Premium, Direct Subsidy) will be calculated with? The instructions currently list this as "not determined." (2) When will CMS release Part D membership counts by plan? (3) How many Part D offerings are allowed by region? A suggestion of 3 has been made but what if we want to file multiple enhanced plans plus two basic alternative plans? (4) Have the LIS Premium calculations been re-weighted for CY2006 yet? If not, when will they be released?	1) No, the methodology has not yet been determined by CMS. We will likely use the latest enrollment data available at the time. 2) This information is released by CBC, not OACT. We believe that the information was released aggregated by organization, and will not be released by plan. Questioner should refer to CBC user group calls (not OACT). 3) See CY2007 Call Letter. Questioner should refer to CBC (not OACT). 4) See CY2007 Call Letter. No information has been determined beyond the Call Letter at this time.

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6	Part D	5/4/2006	4/26/2006 4:40 PM	Follow up to April 26 User Call	I would like to clarify some of the answers I got at the user call today: 1. We can offer the following three plans - actuarially equivalent, basic alternative, and an enhanced alternative with coverage in the gap (I understand there need to be meaningful differences between the actuarially equivalent and the basic alternative plans). 2. The basic alternative plan must have benefits that are actuarially equivalent to the defined standard (as does the actuarially equivalent plan), and not richer (or else it would be an enhanced plan). 3. Our bid for the basic alternative plan can come in higher than our bid for the actuarially equivalent plan. With regards to #3 above - can you give me some examples of why the bid may come in higher. Would a broader formulary justify a higher bid - or would a broader formulary require higher copays to maintain actuarial equivalence (e.g. the formulary would affect our Rx script projections on worksheet 6 of the BPT). Other than perhaps expenses and gain/loss, how might the bids come in at different costs?	Regarding the plan offerings, see CY2007 Call Letter. For further information, questioner should refer plan design related questions to CBC user group calls (not OACT).
7	MA - 2YRL	5/4/2006	4/25/2006 3:03 PM	2 Year look Back - PPO Bid	Do we submit a two year look back if our product was introduced in 2005 and we have one member that joined in November 2005 and no claim experience? We did not receive a 2 Year PPO look back download sheet from CMS in the HPMS.	No. OACT is considering adopting the following guideline. The MA two-year lookback form is to be completed if the contract's base period data is at least 25% credible, or 1,500 member months, based on CMS credibility guidelines.
8	MA - 2YRL	5/4/2006	4/28/2006 5:08 PM	2 year look back questions	I have 2 questions I'd like clarified with regard to the 2 year look back process for the 2007 Bidding cycle. 1) Our organization (Evercare), only appears to have received the 2-year lookback information in HPMS for those contracts (H#s) which were in effect PRIOR to 2005. Contracts which became effective on 1/1/05 (example, H2228) are not listed in HPMS for this data. Does this mean we are not required to submit 2-year lookback forms for these contracts, or is there an error with what's in HPMS? 2) Can you please confirm the timeline for submission of the 2-year lookbacks. Are these also due by the same June 5th deadline?	1. OACT is considering adopting the following guideline. The MA two-year lookback form is to be completed if the contract's base period data is at least 25% credible, or 1,500 member months, based on CMS credibility guidelines.. This policy will apply to all contracts, regardless of whether or not an ACR was filed for 2005. 2. The two-year lookback forms are due on June 5, 2006.

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#	Topic	UGC date	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
9	MA	5/4/2006	5/2/2006 8:43 AM	Member Cost Sharing & Medicare Secondary Payer	Below are two questions regarding the 2007 bids. 1) Can the Plan Cost Share for Medicare Covered Services be greater than the FFS AE Cost Sharing? In other words, can the Maximum Value to reduce A/B cost sharing (cell M25 on Worksheet 6) be negative? The note in cell L25 on Worksheet 6 indicates that if M25 is negative then L25 should be zero. Does this imply that M25 can be negative? Also, can cell G41 on Worksheet 4 be negative? 2) Please provide guidance as to how the Medicare Secondary Payer adjustment should be estimated for the 2007 bids. Has the Medicare Secondary Payer adjustment been factored into the recalibration of the HCC risk scores or do we need to calculate an explicit adjustment? It is our understanding that in 2005, the Medicare Secondary Payer adjustment was applied to the working aged demographic payment. How will the adjustment be factored into the benchmark calculation in 2007 when the CMS revenue is based entirely on risk payments?	1a) For plans with very high levels of cost sharing, it is possible to pass the FFS AE cost sharing test in Section III of WS 4, which is based on standardized values, and have the Plan Cost Share for Medicare Covered Services be slightly greater than the FFS AE Cost Sharing (columns and m on worksheet 4). In this case the cost sharing would be reviewed carefully since we expect that col m > col k. 1b) Cell G41 on WK 4 is Total Net Medical Expense. This may not be negative. There is no "red-circle" edit; however, the reviewer would question this. (Did requestor mean a different cell?) 2) The Medicare Secondary adjustment is applied to risk payments (while the Worked Aged adjustment was a term used for aged demographic payments. The risk model does not explicitly account for MSP. See bid instructions for more information on the explicit MSP adjustment on Worksheet 5 of the MA BPT.
10	MA	5/4/2006	5/2/2006 10:47 AM	Regional PPO Out of Area Travel Benefit	If a Regional PPO has specific member benefits for when a member travels out of the region, how should that be entered into the MA bid tool on the cost sharing tab? Should it be combined with out-of-network cost sharing or should it be entered as a separate travel benefit under the in-network cost sharing?	CMS' preference would be to include the allowed costs associated with this benefit in the appropriate service category (for example, inpatient hospital or professional), and the corresponding cost sharing as out-of-network.
11	MA	5/4/2006	5/2/2006 11:48 AM	Questions For Thursday's Conference Call on BPTs	1) As a basis to project risk scores for 2007, we are running our April 2006 membership through the new risk adjustment model. For some members for which we do not have the right data or software to run the new model (e.g. people who join from other plans, and institutional enrollees), can we use the scores from the Monthly Membership Report divided by 1.05 as an estimate of the scores under the new model ? Such members represent a small part of our enrollment, so any error from such an estimate would have a very minimal impact. 2) Can we go over very quickly, Section IV of Worksheet 4 of the A/B bid on "ESRD Subsidy". The specific question I have is, do we populate cell F66, "CY Medical Expenses for Basic Services" as the Allowed Costs reduced by the Medicare levels of cost sharing ?	1. No, we do not believe that the proposed approach is appropriate. An alternative approach would be to compare the aggregate MMR risk scores for the affected members with the aggregate MMR scores for the remaining population, and make an adjustment to the recailbrated results using this relationship. 2. Per the MA bid instructions, regarding ESRD Basic costs..... All fields in this section are to reflect Medicare levels of cost sharing (e.g., 20 percent cost sharing for Part B services once the deductible has been met) and must be reported on a “per ESRD member per month” basis.
12	MA - ESRD	5/4/2006	5/1/2006 1:52 PM	ERSD Data	There are instructions regarding ERSD membership. However, I find the instructions vague regarding credibility in regards using that data for the bids. The contract number that I am working on has fewer than 100 such members. However, what should I do if the membership has a significant financial impact?	CMS has not released explicit guidance on ESRD credibility, and is relying on the certifying actuary's professional judgment. See bid instructions for information on ESRD bidding.

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13	MA - Duals	5/4/2006	4/26/2006 5:55 PM	Bid question - PBP vs. MPPF vs. BPT for Full-Benefit Dual plans	Hello. This isn't as much a question as it is a request to confirm my understanding of information presented at the Bid Conference earlier this month. As mentioned in Jane Andrews' presentation, "Medicare Advantage Benefits for CY 2007," the PBP is to "…describe the benefits to be offered, including maximum coverage amounts, and the premium and cost sharing to be charged, including any out-of-pocket maximum amounts." Her presentation also describes a Medicare Advantage benefit, and as was the case with 2006 bids, I am proceeding under the assumption that the benefits described in the PBP, as well as those priced out in the bid, are only to be related to the Medicare portion of the benefit (i.e., the "Medicare Advantage" benefit), and not for any other non-Medicare benefit available to members by virtue of the plan being a full-dual plan.	This e-mail has been forwarded to CBC (Jane Andrews) for PBP questions. This issue will be addressed by CMS' Centers for Beneficiary Choices during an upcoming MA/PDP Operational User Group Call. For all bids, including duals, the cost sharing in the BPT and PBP must be on a consistent basis.
13	(continued)				In conjunction with the Medicare Personal Plan Finder, Ms. Andrews also mentioned during her presentation that CMS was working on producing PBP screens that would help dual-eligible plans more fully describe the nature of the overall benefits associated with their plans, not just the Medicare portion of those benefits (since that discrepancy led to a number of plans deciding to suppress the display of their 2006 MPPF data). Finally, on page 12 of Sue Todhunter's presentation, "Special MA and PD Plan Types," it is stated that, "The bid must reflect all plan cost-sharing defined in the PBP even if some or all may not be paid by the State Medicaid Agency." She further went on to state that the bid was not to include cost-sharing amounts paid by Medicaid directly to providers.	
13	(continued)				Therefore, my interpretation of these statements as related to a full-dual plan would be as follows: - That the main portion of the PBP, as well as the Bid, should be built around the Medicare portion of the benefit only; and - That any additional screens developed in the PBP (or elsewhere) which might help full-dual plans describe the combined Medicare/Medicaid benefits under their plan in the MPPF would not have any impact upon the cost-sharing amounts entered in the Bid. I would appreciate it greatly if you could either confirm or correct my interpretation of these statements. Thank you in advance for any enlightenment you can provide.	
14	MA - risk sc	5/4/2006	5/1/2006 2:58 PM	HPMS Risk Scor Links	I need instructions to access the revised risk score for my plan.	Risk scores will be posted in HPMS shortly.

Questions from actuarial-bids@cms.hhs.gov for OACT User Group Call (UGC)

#	Topic	UGC date	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
15	MA - risk sc	5/4/2006	5/2/2006 12:36 PM	MMR Tool.xls	Something that has been useful to us in the past is the MMR tool that helped summarized MMR files and mad it easy to calculate risk scores for plans. Is there a patch for the 2005 .xls file, or a new MMR tool that will accept 2006 MMR files? Also, we are running into an issue when we try to calculate historical risk scores for plans. The adjustments that are made in the MMR file often get made all in one month, making it almost impossible to figure out which month some adjustments should actually be allocated to. Is this a problem other people have run into. We are trying to calculate historical risk scores to use to project 2007 risk scores. Should we be using the 2005 MMR tool for this purpose?	There is not a patch. CMS will investigate if a new Excel tool is available. From the MMR, you can look at the prospective enrollment, or adjust the monthly data for the various historical adjustments. See bid instructions on projecting 2007 risk scores.
1	General	5/11/2006	5/4/2006 12:25 PM	Actuarially related bid questions	Is there a site where I can visit to learn about the actuarial questions and answers?	Questions submitted in writing in advance of the OACT calls are posted on the CMS website, under the following path: Medicare>Medicare Advantage - Rates and Statistics>Actuarial Bid Questions The following is a direct link to this document: http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/downloads/ActuarialBidQuestions.pdf
2	Parts C & D - PROFIT	5/11/2006	5/3/2006 9:22 AM	Profit Margins	What is considered the average industry profit margin?	CMS does not intend to release information regarding average profit margins used for bidding purposes.
3	Parts C & D - ADMIN	5/11/2006	5/9/2006 8:48 AM	Question for Thursday Actuarial Technical User Group Call	Is it acceptable to include management fees as an indirect administration expense on a MA bid? The instructions do not specifically address this question.	In order to provide a response, OACT would need more specifics on this expense element. For example, is the fee paid to a related party, what services are covered under the agreement, how is the fee estimated, does it cover LOBs other than Medicare, etc. The response may vary by plan, as certain management fees would need to be evaluated for applicability to the plan's services under the Medicare LOB. If the fee is paid to a related party, we would need more information on the specific arrangement and a better understanding of how the fee is related.

Questions from actuarial-bids@cms.hhs.gov for OACT User Group Call (UGC)

#	Topic	UGC date	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
4	Parts C & D - ADMIN	5/11/2006	not available	not available	The bid instructions state that "for organizations that have entered into administrative service agreements, the non-medical expense [non-pharmacy expense] must reflect the actual cost of providing services, which may be different than the contractual charge". May an organization use a reasonably estimated commercial rate as the basis for the "actual cost" when they've entered into an agreement with an affiliated company?	We recognize that the organization contracting with CMS may not have the actual cost structure of certain affiliated companies, due to established firewalls between the entities. In these cases, it is acceptable to use a reasonable estimate of the commercial rate for providing the agreed upon services. We expect that the organization would have available an appropriate level of documentation to support the rate development for both bid reviews and bid audits. CMS expects that plans can provide support to CMS reviewers within the same timeframe as other forms of documentation.
5	Part D - instructions	5/11/2006	5/9/2006 9:30 AM	Question	Page 36, Section VIII, Line 2 references “For the 2006 benefit year, this amount …”. Should the reference refer to year 2007 as opposed to 2006?	Yes, there is a typo in the instructions. The Part D BPT instructions language should say "For the 2007 benefit year…"
6	Part D	5/11/2006	5/4/2006 4:55 PM	Questions	This is a follow-up question to one posed during last week's call regarding the "order" of cost sharing: The scenario I was wondering about was not addressed on the user call today. I was asking about the specific scenario where (80%*Allowed + Copay) > Cost. Who gets the break in this situation-- the reinsurance or the member? This happens when a drug is less than $10 and generic (80%*10 + 2.15) > 10, and also when a drug is less than $20 a brand (80%*20 + 5.35) > 20.	It is possible for the plan liability to be negative. For example, if the drug is a $10 generic in the catastrophic, the cost sharing could be as follows: $2.15 beneficiary copay $8.00 reinsurance negative plan liability = -$0.15
7	MA - PBP	5/11/2006	5/3/2006 3:58 PM	Outpatient Rehab Therapy Benefits - PBP	To eliminate the Medicare imposed cap for outpatient Rehab therapy would we state in the note section of PBP that we are covering outpatient Rehab therapy in full? Will this flow through to the SB?	Questions regarding the PBP should be directed to CBC. OACT cannot respond to this question.
8	MA BPT	5/11/2006	5/5/2006 8:37 PM	A/B Worksheet #1, #14	For A/B Worksheet #1, line #14 is labeled "% of CY Enrollees that are Dually-Eligible". Last year this represented the population in the base period year. And I don't believe this was mentioned as a change. However, the bid instructions say: "Enter the percentage of projected enrollees that are dually eligible, i.e. eligible for both Medicare and Medicaid, during the contract period." Please clarify (a) base period or (b) contract period.	This field is to be used to report data for the projected Contract Year, not for the base period. While the field is located on Worksheet 1, note that it is located in the general information section (Section I), and is not related to base period data.

Questions from actuarial-bids@cms.hhs.gov for OACT User Group Call (UGC)

#	Topic	UGC date	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
9	MA - 2YRLI	5/11/2006	5/4/2006 3:51 PM	2-Year Look back	Our plan (H3336) was a new plan in 2005 with start date of 3/1/2005. We have just over 7000 member months in 2005 for the whole contract. On HPMS, there is no 2-year lookback projection data under my user. Do we need to complete this form, because our understanding was that the 2005 projection data would already be populated. If we do not need to complete the 2-year look back do we need this in writing from CMS?	On previous calls, OACT has stated that CMS was considering adopting the following guideline: "The two-year lookback form should be completed if the contract's base period data is at least 25% credible, or 1,500 member months, based on CMS credibility guidelines.. This policy would apply to all contracts, regardless of whether or not an ACR was filed for 2005." OACT has since confirmed the 2YRLB upload requirements defined in HPMS. Therefore, we would like to clarify our position as follows: If a contract does not have the CY05 ACR data provided in HPMS, then they are not permitted to upload a 2YRLB. In other words, if a contract (H #) has not submitted a CY2005 ACR, (and thus do not have data provided in HPMS), then the contract is not required to upload a 2YRLB. If a contract does have CY05 ACR data in HPMS, then they are required to submit a 2YRLB, regardless of the level of membership. Contracts with CY05AR data that do not submit the 2YRLB will not be properly uploaded to HPMS for desk review.
10	MA - ESRD	5/11/2006	5/3/2006 5:27 PM	Excluding ESRD data	When ESRD data is excluded from the experience (& for the section where it's reported by itself), which of the following method is used to separate out the ESRD data: --the time period that they're effective & we know they're an ESRDs member (even if we're not getting paid from them being an ESRD member yet) --the time period that they're effective & our payment is based on them having an ESRD indicator on the MMR --their entire experience during the reporting time frame if they're an ESRD member at all during the reporting time frame	The timeline should be based on CMS eligibility records. Of course, often the MMR payments lag for a month or two when an enrollee switches from non-ESRD status to ESRD status, but retroactive adjustment records will ultimately make the plan "whole." Once the enrollee has been determined to be ESRD, the expenses should be separated. For example, if the ESRD status is effective in Feb but not known until May, then the expenses between Feb-May should be separated.
11	MA - SNP	5/11/2006	5/4/2006 11:45 AM	Special Needs Plan	On last weeks call, it was discussed that a special needs plan for duals can provide a bid based on one of two benefit designs (cost sharing for Medicare covered benefits). $0 cost sharing, which would likely produce a beneficiary premium Medicare FFS cost sharing, which could produce a $0 beneficiary premium Is a plan permitted to bid on a plan design that has copays somewhere in between the two designs above, which may produce a beneficiary premium?	The short answer is "Yes", but this plan should contact CBC for more specific information on design of PBP for special needs plans. The corresponding actuarial bid requirement is that the bid be developed consistent with the PBP (both the development of allowed costs and enrollee cost sharing).

Questions from actuarial-bids@cms.hhs.gov for OACT User Group Call (UGC)

#	Topic	UGC date	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
12	MA - risk scores	5/11/2006	5/8/2006 11:01 AM	Actuarial Bid Questions	We have the following questions regarding frailty factors: For plans that receive the frailty factor in their risk score, is that portion of the risk score also adjusted by the FFS normalization factor? Or, is the HCC07 risk score divided by 1.029 and then the frailty factor added on top of that? Are frailty factors impacted by the new HCC model? Have the frailty factors changed from 2005 to 2007?	The risk score is divided by 1.029 and then the frailty factor is added on top of that. The frailty factors have changed slightly between 2005 and 2007. See the final payment notice for more information.
13	MA - risk scores	5/11/2006	5/8/2006 1:50 PM	MMR Tool.xls	In your weekly call, you mentioned that the impact of the new risk adjustment model, by plan, would be out on HPMS. You also mentioned that there would be guidance on how to project these risk scores forward to 2007. Can you tell me where we can find both of these items.	Today (May 11th, 2006) recalibrated risk scores were released via HPMS. The risk scores are based on a May06 cohort. Technical notes were released that contain additional guidance.
14	MA - risk scores	5/11/2006	5/9/2006 8:12 AM	risk scores	On the 4/27 and 5/4 user group calls, you recommend trending our risk scores to July 2007. Why July and not December? I believe that prior month payments are adjusted retroactively to account for higher risk scores as more encounter data come in, so doesn't the December risk score represent the calendar year more appropriately? Or is the July period preferred due to the age component of the risk score?	Our research indicates that the average plan risk scores decline throughout the payment year. Therefore, the July cohort is generally considered to be the most reasonable. See the revised MA bid instructions (pages 34-36) for more information.
15	MA - risk scores	5/11/2006	5/9/2006 11:11 AM	Risk Score Recalibration	I thought that there would be new information on HPMS regarding the risk score recalibration. What is the expected time frame for posting?	See response to #13.
1	MA and PD - User Fees and Crossover Fees	5/18/2006	5/15/2006 4:04 PM	2007 Bid Questions	What value should be used in the MA bids for the CMS user fees? What value should be used in the part D bids for the CMS user fees and the Crossover fees?	The Medicare User Fees for CY2006 were 0.041 percent (or 0.00041) of Part C and Part D program expenditures. CMS estimated the CY2006 fees on a standardized basis to be $0.32 PMPM for Part C and $0.08 PMPM for Part D. The Part D Crossover fees for CY2006 were $1.00 PMPY (per member per year). CMS expects a comparable estimate to be used in the CY2007 bids.
2	MA and PD - User Fees and Crossover Fees	5/18/2006	5/16/2006 1:29 PM	Crossover and User Fees	Last year you released supplemental bid instructions regarding the amounts to be included in the bids for Crossover and Medicare User fees. At the bidding conference you verbally said that these amounts are not changing this year. Is this documented anywhere?	See response to #1.
3	MA and PD - PROFIT AND PREMIUMS	5/18/2006	5/10/2006 2:46 PM	Questions for 5-11-06 Actuarial Technical Call	If a plan is experiencing a divergence in required premiums across benefit plans and service areas, which cannot be explained by the actuarial value of benefit differences, risk scores, reimbursement level differences, etc., and the divergence is creating significant hurdles to remaining competitive, how would CMS expect that to be handled? It is our understanding that CMS expects to see consistent profit levels across plans, but varying profit would be one very helpful way to stabilize premium relationships and remain competitive in the market. How much flexibility will CMS allow the plans in this situation in terms of profit levels? Another alternative is to combine currently separate service areas into one to bring premiums to more appropriate levels; does CMS have any concerns or limitations with respect to service area changes?	Consistent with BPT instructions and other CMS guidance, variation in margin levels across bids offered by an organization are to be based on "bid specific" factors. Variation in margins across bids offered by an organization should be supported by bid specific factors and documented in accordance with the bid instructions. Service area questions can be sent to CBC's bid contact, Yasmin Galvez, at yasmin.galvez@cms.hhs.gov.

Questions from actuarial-bids@cms.hhs.gov for OACT User Group Call (UGC)

#	Topic	UGC date	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
4	PD - BPT and instructions	5/18/2006	5/13/2006 9:22 PM	OACT User Group Call question	Will you clarify the proper use of section VIII on Worksheet 5 (Rx Alternative Coverage) in the Part D BPT? In the instructions for Line 2, the first sentence reads "Enter the additional basic Part D costs in the first column if the utilization for alternative coverage was used to price defined standard coverage". Should this read " ... in the first column as if the utilization ... "?	Yes, "as if" is a more appropriate wording of this section of the Part D bid instructions.
5	PD - BPT and instructions	5/18/2006	5/15/2006 4:43 PM	Part D induced utilization adjustment	Could you please expand on instructions for Section VIII of WS6 of the Part D bid forms, to elaborate on the correct basis for the induced utilization adjustment? Specifically, is the adjustment applied to the defined standard bid to arrive at the target? If there is a large amount of selection effect causing higher costs in the enhanced plan, to what extent should that selection effect be included in the adjustment?	Question should refer to Worksheet 5 (not worksheet 6, as the question indicates). Response: Refer to the Part D bid instructions and the response to #4.
6	PD - payment demonstration	5/18/2006	5/15/2006 8:28 AM	Part D Demonstration Question	The May 10, 2005 Instructions for the Part D Payment Demonstration included a "Capitation adjustment for budget neutrality" of $3.13. What is the amount for 2007? How is this adjustment applied; meaning is it netted out somewhere in the bid form or if not where?	The CY2007 amount has not yet been released. The adjustment is applied as part of the year end reconciliation. The estimate for CY2007 should be included in the Direct Administration expenses.
7	MA and PD - BPT	5/18/2006	5/10/2006 11:06 AM	Questions For 5/11 Call With OACT On Bids	1) Could OACT put together a simple example of how the Part D risk corridors work under the flexible capitation demo ? We know the calculation is different than the non-enhanced plans as the risk corridors are determined off a target amount that includes reinsurance. We also know induced utilization is also part of this calculation. A simple example would better help us understand how this reconciliation will work in 2007 for our 2006 demo plans. 2) Any update on the release of regional based Part D benchmarks for LIS ? 3) Apart from ESRD (we will include ESRD in Worksheet 4 of the A/B bid) & Hospice expenses, are there any other medical expenses that must be excluded from our 2005 base experience shown in Worksheet 1 of our A/B bid? 4) Is it correct to assume that the ESRD & Hospice related drug experience should be included in our 2005 base experience that is used to project 2007 drug claims ?	1) To expand on the risk corridors for the flexible capitation demo... The amounts for reinsurance costs are included in the risk corridor calculation. 2) These are not yet released by CMS (as of 5/18/06). See the CY2007 Call Letter for more information. 3) No. 4) Assuming the question refers to Part D drug expenditures - there are no exclusions for ESRD nor hospice in the Part D BPT.
8	MA - BPT	5/18/2006	5/10/2006 7:53 AM	MA BPT Question	For plans that have no experience and therefore no base experience data, could you confirm that we should fill out worksheets 1 and 2 as follows: Worksheet 1, Section 1: Completely fill out Worksheet 1, Section 2: Do not fill out Worksheet 1, Section 3, Fill out column F (Util Type) only Worksheet 1, Section 4: Do not fill out Worksheet 1, Section 5: Do not fill out Worksheet 2: Completely fill out using manual data.	Yes, that is correct. Plans that are not projecting expenses using base period data should complete the general information section I of Worksheet 1, and the utilization types for each service category in column F. These utilization types are carried forward to Worksheet 2 and should correspond to the data entered on Worksheet 2 for the manual rates.

Questions from actuarial-bids@cms.hhs.gov for OACT User Group Call (UGC)

#	Topic	UGC date	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
9	MA - BPT	5/18/2006	5/10/2006 11:58 AM	BPT	If changes will be made to the bid tool using the BPT.xla file, will we receive a list of the changes that were made along with the new release of the file?	Please note that a new version of the BPT.xla was recently released in HPMS for a technical/upload issue. All users must download the newest release of the BPT.xla in order to properly upload their BPTs. HPMS contains release notes that describe the changes made to the BPT.xla.
10	MA - BPT	5/18/2006	5/12/2006 11:51 AM	Worksheet 3 - Travel Benefit	This year, the PBP requires us to enter a detailed description of the travel benefit, which is a change from last year. As a resulte, do we need to be include the impact of the trqavel benefit on Worksheet 3? If so, should it be classified as OON ?	The PBP and BPT must be completed on a consistent basis. The BPT must reflect all the benefit provisions and cost sharing contained in the PBP. As stated on the 5/4 UGC: CMS' preference would be to include the allowed costs associated with this benefit in the appropriate service category (for example, inpatient hospital or professional), and the corresponding cost sharing as out-of-network. For a plan with no other out-of-network cost sharing, the plan may choose to enter the travel benefit cost sharing as a separate service category line on Worksheet 3.
11	MA - using MMR data	5/18/2006	5/15/2006 12:44 PM	Item 14 of Sect 1 of Wkst 1 of MA BPT	When calculating item 14 of Section I on Worksheet 1 of the MA BPT (the "% of CY Enrollees that are Dually-Eligible")1, should we use column 19 or 21 on the MMR?	The plan should use field 19, this is the concurrent monthly medicaid indicator from the MBD (source is the 3rd party buyin file and the plan reported medicaid). Field 21 is the risk adjustment Medicaid indicator which indicates at least one month of medicaid in the risk adjustment data collection year.
12	MA - using MMR data	5/18/2006	5/15/2006 3:19 PM	Medicare Secondary Payer Adjustment on Wkst 5	Could you elaborate more on how the Medicare Secondary Payer Adjustment is determined in Worksheet 5 (cell E14). Item 16 (Working Aged) on our 2006 MMR files are blank, but I've been told by our membership area that we had 19 working aged members as of March 2005. I looked at the MA BPT instructions from last year, & they're similar...but I didn't see the "Working Aged" field on the 2005 MMR. Please help me to understand how to calculate this adjustment based on the MMR.	Per the BPT instructions, the MSP adjustment can be based on MMR data. However, please note that the Plan Payment Report displays these ratios and might be a better source than the MMR for estimating 2007 ratios. The basis for this estimate of course begins with the surveys of plan membership in March of the previous year. The plans may need to look at the survey data on a plan by plan basis (as opposed to contract) to develop ratios for the BPT.
13	MA - EGWF	5/18/2006	5/10/2006 2:01 PM	Question: PFFS EGWP Bids	1. Should PFFS EGWP bids include every county in the US? 2. If the answer to question one is "Yes", and we are projecting 0 members in some counties, should we include these in the bid with 0 members, or have a 1 member placeholder? 3. If the answer to question one is "No", how will we be paid if we sell a member in a county not originally included on the bid?	1) It is not required, but it is strongly recommended for PFFS EGWP plans that represent a national service area to include every county in the US. 2) In the CY2007 MA BPT, the enrollment reporting reflects 'member months', not 'average members'. There is no requirement that a county must have at least one projected member month.

Questions from actuarial-bids@cms.hhs.gov for OACT User Group Call (UGC)

#	Topic	UGC date	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
14	MA - risk scores	5/18/2006	5/10/2006 11:27 AM	Question regarding HCC scores	I am concerned about the HCC scores that should be released shortly for the May 2006 risk scores. My concern is that the population could have changed from July 2005 to May 2006 and therefore the historical data would not accurately reflect the projected medical costs. How should a plan handle a situation like this, should we adjust the MA Base Plan data or should we adjust expected risk scores? My assumption is that you would have us change the Base Plan data, but I wanted to verify this. A couple of reasons why the population would have changed. We were significantly above the benchmark for 2006 and therefore our Rx membership was priced much higher than our competitors and significant movement occurred. Also, with plan designs and the new benefits there are differences to be expected. I apologize in advance if our risk scores turn out to be similar and the question becomes moot. We checked this morning and the new risk scores were not available.	The base plan data should represent actual program expereince and should not be changed to reflect subsequent changes in plan population. The preferred approach for developing the bid under this sitiuation is to make an appropriate entry into the "population change" column in Worksheet 1, Section IV, column l, and to provide a synopsis of the adjustment in Worksheet 1, Section V.
15	MA - risk scores	5/18/2006	5/15/2006 12:39 PM	MA Wkst 5 Risk Score Development by County	At the bottom of page 36 of the new MA BPT instructions after the risk score development example, it says, "Please note, that the above example would typically apply to individuals enrolled in ALL counties in the plan's service area." Does that mean that we should use the same risk score for all counties within our service ares? Or should we go through the calculation as outlined, & then adjust the scores proportionately to the current risk score relativities between counties?	Either approach is acceptable. However, the resulting plan-level score developed using the county-specific approach must equal that would otherwise be developed using the aggregate approach. See the documentation section of the bid instructions regarding risk score development.
1	MA and PD - Non-Medical Expenses	5/25/2006	not available	Administrative Service Agreements	The bid instructions state that "for organizations that have entered into administrative service agreements, the non-medical expense [non-pharmacy expense] must reflect the actual cost of providing services, which may be different than the contractual charge". May an organization use a reasonably estimated commercial rate as the basis for the "actual cost" when they've entered into an agreement with an affiliated company?	We recognize that the organization contracting with CMS may not have the actual cost structure of certain affiliated companies, due to established firewalls between the entities. In these cases, it is acceptable to use a reasonable estimate of the commercial rate for providing the agreed upon services. We expect that the organization would have available an appropriate level of documentation to support the rate development for both bid reviews and bid audits. CMS expects that plans can provide support to CMS reviewers within the same timeframe as other forms of documentation.
2	MA and PD - Actuarial Certificatio n	5/25/2006	5/17/2006 9:32 AM	Actuarial Certification	Please clarify the following, included in the Actuarial Certification sample language: ...the bid is based on the "average revenue requirements in the payment area for an [Medicare Advantage/Prescription Drug] enrollee with a national average risk profile" Please focus on the meaning of the term "national average risk profile" vis a vis the Plan Bid, which is at the risk profile of the projected membership, not a national average.	In the bid pricing tool, organizations project costs under the expected risk score of the projected population. These costs are then "standardized" to a 1.000 average Medicare beneficiary, using the plan's projected risk score. This 1.000 average beneficiary represents the "national average risk profile".

Questions from actuarial-bids@cms.hhs.gov for OACT User Group Call (UGC)

#	Topic	UGC date	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
3	MA and PD - OTC	5/25/2006	5/24/2006 9:34 AM	Question on OTC coverage	The guidance regarding over-the-counter (OTC) coverage in the actuarial bid questions states that Part D plans may include OTCs as direct administrative expenses. Can you please verify that this guidance applies to both PDPs and MA-PDs? Thus MA-PDs could include OTC as direct admin on their Part D bids, or as a supplemental benefit on their Part C bid.	Yes, MA-PDs may include OTC as direct admin in their Part D bids, or as a supplemental benefit in their Part C bid.
4	PD - LIS	5/25/2006	5/24/2006 11:54 AM	LIS	Are there any updates to the national benchmark for the low income subsidies? What did 2006 results look like?	We are currently considering an option that will allow benchmarks to be calculated in a manner such that any facilitated changes in LIS beneficiary enrollment will be limited. Please check HPMS for announcements on this issue.
5	PD - BPT	5/25/2006	5/17/2006 7:30 PM	BPT for Part D, Worksheet 5, cell G37	For members who exceed the $2,400 ICL in total spending, why is the formula for alternative allowed PMPM the same as the standard allowed PMPM? We would assume more members to exceed the ICL with enhanced alternative coverage than we do with standard coverage. So, the allowed PMPM for alternative would be higher than standard for members over the ICL. This would lead to higher net benefit costs, higher supplemental coverage, and higher supplemental premiums for enhanced alternative plans.	As indicated in the Part D BPT instructions, amounts in Worksheets 5 and 6 are based on the expected cost distribution for individuals as if under the Defined Standard benefit.
6	PD - BPT	5/25/2006	5/22/2006 7:05 PM	Question For 5/25 Call On Bids	Due to administrative reasons, one of our plans would like to file basic alternative Part D instead of Standard Part D for its dual SNP bid even though 100% of these members will be LIS. Is this permissible ?	Yes, this is permissable.
7	PD - BPT	5/25/2006	5/22/2006 8:08 PM	Non-Part D Drugs	On a Basic Alternative plan, the cost of non-Part D drugs does not get added to the bid on Worksheet 5 (the cost of the drugs are less than $0.50). Will the cost for these drugs be added automatically to the member premium?	Plans that cover excluded drugs must be enhanced alternative plans. The Part D BPT includes a rounding rule such that plans with supplemental premiums of less than $0.50 are rounded down and are considered basic alternative plans. For a plan to satisfy these two conditions, plans that cover excluded drugs must have supplemental premiums of at least $0.50.
8	PD - BPT	5/25/2006	5/23/2006 2:55 PM	MA-PD drug premium buy-down by H# or by plan ID?	I can't find the answer to these questions anywhere. For an MA-PD plan my understanding of the regs is that they can offer a drug benefit as long as they charge zero premium by using all rebates to buy-down the premium. Then, they don't have to offer the Part D basic benefit. My questions are: Is the above applicable at the H# level or is it at the plan ID level? Or does it matter (ie. Same for both)? Is there any difference in the answer if the service area is different?	The requirement is that every service area must have a zero premium or basic Part D plan.
9	PD - BPT	5/25/2006	5/24/2006 10:55 AM	PD-BPT	On the script projection page are you required to enter an amount for OON? Also, On the script projection page I get the red circles for Non-Preferred Brand stating the value should be greater than 0 if the associated member months are greater than 0. Our formulary does not contain non-preferred brand drugs so we don't have any utilization for them. How should I handle this error message?	The BPT should reflect the plan's projected OON usage. The amount is not required to be greater than zero, but you should report the projected assumption. You can ignore that particular red-circle validation error in this instance.

Questions from actuarial-bids@cms.hhs.gov for OACT User Group Call (UGC)

#	Topic	UGC date	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
10	MA - BPT	5/25/2006	5/22/2006 4:42 PM	Excess Rebates	If after the national Part D benchmark is set if a plan has excess rebates to reach its Target Part D premium can it use those rebates to further reduce A/B cost sharing. For example drop a inpatient copay from 350 to 300 if the value of that reduction equals the excess rebates?	See Attachment B of the MA/MA-PD CY2007 Call Letter for detailed guidance regarding rebate reallocation.
11	MA - BPT	5/25/2006	5/18/2006 12:25 PM	2007 Bid Question -- FFS Benefits	Our organization has several Demonstration plans that we are instructed to Match fee-for-service benefits on. We are required to submit bids and/or PBPs for 2007 on these plan -- has CMS finalized what the FFS benefits will be for 2007 yet, and if so how can we access those? For example, will the Inpatient hospital stay change from $952 in 2007, or the plan-level deductible change from $124, etc.? There are numerous benefits such as these examples which could vary.	The CY2007 FFS benefits will not be released by CMS before bids are due. Plans should be able to estimate the CY2007 FFS benefits in the Bid Pricing Tool, based on the actuarially-equivalent-cost-sharing factors in the BPT (to result in zero cost sharing "buydown"). The release of the actual CY2007 FFS benefits should not require a change/resubmission of the BPT. However, the PBP may need to be resubmitted. Questions regarding the PBP should be directed to CBC, not OACT. The PBP and BPT must be completed on a consistent basis. Plans should clearly label in Worksheet 3 that they are estimating FFS cost sharing.
12	MA - BPT	5/25/2006	5/18/2006 1:08 PM	Question About SNP Cost Sharing	We're working on our PBP for a dual eligible SNP in Virginia and are trying to decide how to specify the cost sharing. Our bid is for a PPO benefit. We intend to use standard Medicare cost sharing for in-network benefits (knowing Medicaid will pick up their usual cost sharing). However 2007 cost sharing hasn't been finalized. Should we insert 2006 cost sharing in our PBP/bid? If so, how will we be able to change to 2007 cost sharing when that's finalized?	See response above to #11.
13	MA - BPT	5/25/2006	5/18/2006 3:29 PM	SNP Bid question	Question: on our 2007 bid, may we use Medicaid dollars (those that are intended for subsidizing the Medicare coinsurance and deductibles) to pay down our SNP plan premium to zero?	See page 19 of the MA/MA-PD CY2007 Call Letter regarding plans serving Qualified Medicare Beneficiaries (QMB). For a response to this specific question, please contact Cheri Rice or Mike Fiore in CBC.
14	MA - BPT	5/25/2006	5/22/2006 5:50 PM	FW: Section II, MA bid form W1	Within Section II, item 5, on MA bid form Worksheet 1 there are four lines to input distinct contract IDs that comprise the base period data. What do we do if we have more than four such contract IDs (Xxxxx-xxx) within the data?	Enter the four most prevalent plan IDs (i.e., those with the highest percentage of member months used in the base period). Plans with base period data that is comprosed of experience of more than four plan IDs should fully describe the base period data (with all plan IDs listed) in line 6 of Section II of Worksheet 1. Plans may also upload supporting documentation, as needed.

Questions from actuarial-bids@cms.hhs.gov for OACT User Group Call (UGC)

#	Topic	UGC date	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
15	MA	5/25/2006	5/23/2006 12:59 PM	Private-Fee-for-Service Plans	1. For Private-fee-for service plans, can MCOs have different rates for providers by region/market? In this case, the rates would not be contracted but published on the website. 2. If plans have a network in place with rates that are different from 100% Medicare, can those rates be accessed under PFFS if the contract allows for it?	1) Most of our pffs plans are non-network models. And it looks like the first question pertains to this type of plan which has no written contracts. Plans must may at least the same as Medicare. Since Medicare pays differently in different states and/or localities, plans must do the same. In any given area, pffs plans must pay all providers of a given type the same amount. 2) A pffs plan can have rates lower than that of Medicare under a written contract. The plan needs to have adequate access for it's members with these network providers. But, unlike a PPO, a pffs plan must pay this same lower rate to all providers, including those that are out of network. However, the pffs plan can have higher cost sharing with non-network providers. But the plan's portion plus the member copays must add to the same amount for both network and non-network providers. Rates can also be greater than Medicare. But once again, the total payments must be the same for network and out of network providers. The MA Out of Network Payment guide can be downloaded from the CMS website at the following location: http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/
16	MA - trends	5/25/2006	5/8/2006 10:10 PM	Medicare FFS Trends for Bids	IF an MCO has contracts that are a % of Medicare, we wanted to build the unit cost components of trends using FFS Medicare as a baseline. Per your recommendation from technical user group calls, I looked in the 2006 trustees report but the report does not easily break out unit cost vs utilization at a per beneficiary level. After some research, here is what I have been able to gather so far as best estimates for unit cost trends from 2006 to 2007. [ATTACHED DOCUMENT, NOT ATTACHED HERE] Are the above numbers correct? If not, can you provide the corrections Please note that we are only looking at unit cost (unit price) changes. For physician, because of legislative changes, we will assume an increase in the range of 0-2%. We will use our experience to build utilization trends as needed. Also, where do I get best estimates on 2005 to 2006 restated trends. Here are the estimates that I have - some of these are from last year and may not be the most current. [ATTACHED DOCUMENT, NOT ATTACHED HERE]	See the below response to #17.

Questions from actuarial-bids@cms.hhs.gov for OACT User Group Call (UGC)

#	Topic	UGC date	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
17	MA - trends	5/25/2006	5/23/2006 12:01 PM	Unit Cost Medicare trends 2006 and 2007	Please provide unit cost trends for Medicare FFS from 2005 to 2006 restated and best estimates for 2007 as of today for the following categories. 1. DRG PPS 2. SNF 3. Home Health 4. ASC, OP Surgery 5. Outpatient Lab 6. Other OP Hospital 7. DME 8. Physician	1. DRG PPS (2006: 3.7%; 2007: 4.0%) 2. SNF (3.2% ; 3.8%) 3. Home Health (0%; 3.7%) 4. ASC (0.0%; 0.0%) 5. Outpatient Lab (0.0%; 0.0%) 6. OP Hospital, other than lab (3.7%; 4.0%) 7. DME (0.0%; 0.6%) 8. Physician (0.2%; -4.6%)* * All 2007 updates based on current law (as of 5/25/06)
18	MA - ESRD	5/25/2006	5/23/2006 10:13 AM	ESRD & Worksheet 4 of A/B Bid	Any more guidance on ESRD member months that are fully credible ? We are using a full credibility of 6,000 base period member months for ESRD. If our member months are less than 6,000 could we use partial credibility & blend with manual rates , similar to what we do in Worksheet 2, to populate Section IV of Worksheet 4 in our A/B bid ?	OACT has not set specific standards regarding ESRD credibility.
19	MA - 2YRLB	5/25/2006	not available	not available	According to the BPT instructions for 2007 bids, the Original Projection section of the form is to be populated by the CMS per the ACR information in the HPMS system for CY 2005. We do have ACRs filed in the HPMS but the two-year look-back form only contains the H # and organization name after I completed the PBP data entry software and plan-specific information download procedures according to the CMS instructions. Will you please help me with identifying the possible missing steps or additional procedures that need to be done in order for the form to be appropriately populated?	These columns are not actually pre-populated with information, but rather should be populated (by the user) using information from CMS. Plans can download the information needed from HPMS (under HPMS Home>Plan Bids>Bid Submission>CY2007>Download>2-Year Lookback Projection Data), but the user needs to enter this information into the form. If plans have 2YRLB data in HPMS (at the above path), then they are required to upload a 2YRLB form with their bid.
20	MA - risk scores	5/25/2006	5/16/2006 8:01 PM	Risk Scores	If a Medicare Advantage Plan offers two Plan IDs, one MA only plan and the other an MA/PD plan with the same MA benefits, is the plan permitted to pool the projected risk scores even if the YTD 2006 risk scores appear to be different between the two plans? This was one benefit plan in 2005; therefore the base period experience will be the same. It is early in the year, but it appears (based on the January-May MMRs that there is a difference in the risk profile of those electing the two plans). The enrollment is very low in one of the plans (704 members) vs. the other plan (over 2000 members). If CMS requires the plan to reflect the different risk scores, the base period experience will be adjusted accordingly for each plan benefit package.	Organizations can choose to pool the experience or project them separately. However, the resulting standardized bid must reflect a reasonable expectation of the results for each plan, based on historical and other information.

Questions from actuarial-bids@cms.hhs.gov for OACT User Group Call (UGC)

#	Topic	UGC date	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
21	MA - risk scores	5/25/2006	5/17/2006 6:04 PM	Question for Actuarial User Group Call	I am working with an Institutional SNP plan and am having difficulty reconciling to the May-06 risk scores published by CMS. Based on a review of CY2005 and YTD2006 MMRs and Plan Payment Reports, I do not feel comfortable using the risk scores published by CMS as a starting point for projecting the 2007 risk score. I believe the disconnect between the May-06 risk scores projected by CMS and me are ultimately a result of how a member is classified between Institutional and community. Regarding the development of the May-06 risk scores published last week: 1) How does CMS define the status of a member (e.g., community vs. institutional) for the calculation of their risk score? Has this changed in 2006 versus prior years? 2) If CMS uses the members status indicated in "RA Factor Type Code" field of the MMR, how often is this indicator adjusted for retro-active status changes? 3) How does CMS adjust risk based payments for retro-active Institutional status changes and where are these payments tracked? Are they at the member or plan level? Are they included in the HCFA plan payment reports?	Institutional SNPs may experience fluctuations in their risk scores. In response to the questions posed: 1) The status is based on where the member resides (for ex., long term institutional for 90 days prior to the payment period). No, this has not changed, but we've updated the underlying data. 2) CMS does use the "RA Factor Type Code", and it is updated when the risk scores are updated. 3) This is tracked at the individual level on the MMR.
1	MA and PD - GENERAL	6/1/2006	5/25/2006 12:51 PM	Question on Bid Deadline Time	We understand the Medicare Advantage Bids are due June 5th. Please provide us with the exact time of the deadline.	Excerpt from page 57 of the CY2007 MA/MA-PD Call Letter: Organizations may upload their plan bids one or more times between May 19, 2006, and the CY 2007 bid deadline of **12:00 midnight PDT** on June 5, 2006. CMS will accept the last successful bid upload received for a plan by this deadline as the official bid submission for that plan
2	MA & PD - SUPPORTING DOCUMENTATION	6/1/2006	5/30/2006 10:30 AM	Question Backup Documentation	In HPMS where the data is uploaded there are three different areas to upload backup documentation, 1. Cost Projections/Development of Manual Rate 2. Administration/Profit/Development or Allocation 3. Miscellaneous. In the MA and PD BPT instructions there is a list of documentation to be submitted with the bid and documentation to be submitted upon request from CMS, could you list where each of the items should be uploaded into HPMS? Thank you for your time.	To expedite bid reviews, OACT requests that all supporting documentation for a particular bid be "zipped" into one ZIP file. If the zip file contains multiple files, we would appreciate it if an outline, or a table of contents, could be included as a file that briefly describes all of the files included in the zip file (and clearly labeled as the table of contents in the filename). This will expedite our review of the supporting documentation. The zip file could be uploaded under the appropriate section, at the actuary's discretion. One possible method - If the zip file contains information regarding administrative expenses and/or profit (as well as other support), the zip file could be uploaded under the #2 option (Admin/Profit). If multiple files are uploaded (not zipped), plan should submit admin and profit support under #2, and any support for medical cost development under #1. We ask that plans generally try to avoid using the miscellaneous category #3.

Questions from actuarial-bids@cms.hhs.gov for OACT User Group Call (UGC)

#	Topic	UGC date	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
3	PD - LIS	6/1/2006	5/27/2006 10:13 PM	RE: Actuarial Questions	If a part D plan strongly believes that having a bid at or below the low income benchmark materially impacts their pricing assumptions, can they submit two bids, one bid to apply if they are at or below the low income benchmark and the other to apply if they are above?	No, organizations are not permitted to submit two bids as described in this question. The bid submission on June 5th should reflect the plan's best expectations regarding the assumed enrollment. Plans that believe the LIS policy will have a significant impact on their bid assumptions should upload supporting documentation that demonstrates the potential impact of the LIS policy on specific bid assumptions.
4	PD	6/1/2006	not available	not available	Regarding MA-PD plans: We are using an estimated national average bid in our look at member premiums. Some of our regions are coming in lower by such an amount that on the BPT, it would show a negative premium amount. Clearly, a negative member premium does not make any sense. How should this be corrected?	Since the premium that you submit in your bid will be your target premium, you should adjust your expectation of the national average/direct subsidy for the affected plans such that the basic Part D premium is zero. You should have one national average/direct subsidy amount expectation in your bids with variations only to support a zero basic premium. Plans in this circumstance should, as part of the supporting documentation, upload a matrix with the various national average bid expectations for each plan. For those plans that vary, the matrix should indicate that the variation was to yield a zero premium for the basic D premium prior to rebates.
5	PD	6/1/2006	5/31/2006 8:42 PM	OACT question	Does the drug bid for a B only plan need to be a basic drug bid, or can it be enhanced?	Assuming this question refers to an MA-PD Part B Only plan, then the same requirements would apply as all other MA-PD plans. For instance, the organization must offer one drug plan benefit in all service areas that is either a Basic plan or has a $0.00 (zero) supplemental premium (after the application of A/B rebates).
6	PD	6/1/2006	5/31/2006 1:13 PM	Part D Question	A client is completing the Part D BPT for the Defined Standard Plan. The pricing is compared under two scenarios: (1) drug rebates are received by the plan retrospectively and are accounted for on the “Rebates” line (BPT Worksheet 3, Section III, Line 7); and (2) the drug rebates are applied at the point of sale thereby reducing the cost/script as well as eliminating the entry on the “Rebates” line.	CMS recognizes that there is an impact on the bid pricing assumptions whether the price concessions are applied at the point of sale or sometime thereafter.
7	PD - BPT	6/1/2006	5/26/2006 3:27 PM	Enrollee Type?	In the PDP BPT instructions for Worksheet 1 section 1 line 9 Enrollee Type it states to select from the drop down manual. Making a choice causes a validation error for our stand alone plans. Can we just leave that cell blank even though it causes a red circle to appear for our stand alone plans?	The HPMS staff has informed us that PDPs should leave the enrollee type field *blank* in the Part D Bid Pricing Tool (BPT). PDPs should ignore the red circle validation on this cell when it is left blank. For MA-PDs, this field should be consistent between the BPT and PBP.
8	PD - BPT	6/1/2006	6/1/2006 9:58 AM	Part D BPT Regions	We are submitting 4 bids, all are for local plans; 2 of plans include only one county; 2 of the plans include 4 counties. On Worksheet 1, General Information, PD Region should we use "N/A" as the drop down box implies would be the option for local plans or do we need to choose the region that the local plans are in (e.g., "22" for our Harris County Texas SNP) as page 15 of the Instructions implies? Page 15 does not address the N/A option at all.	Local PD plans would select N/A for PD Region field.

Questions from actuarial-bids@cms.hhs.gov for OACT User Group Call (UGC)

#	Topic	UGC date	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
9	PD & MA	6/1/2006	5/27/2006 12:49 PM	Actuarial Questions	1) Does the law give CMS the ability to make a modification to the Part D payment demonstration that would give plans the option to use full allowed risk score coefficients in place of the defined standard benefit factors? Alternatively, can a plan propose an alternative set of factors that reflect the benefit corridors of the demonstration plan? Will you consider this potential change for 2008? 2) During the August re-bid, can a plan move mandatory supplemental benefits to optional supplemental benefits? 3) Is it acceptable to pool MA-Only and MA-PD plan experience (risk scores, claims, admin etc) when there is no intended medical benefit difference in order to avoid incenting members to drop drug coverage (by keeping the part c member premiums identical)? [The plan does not wish to drive people out of drug coverage, but rather encouraging them to keep it.] 4) Why can't we allocate ESRD costs between the bid and mandatory supplemental benefits on the required revenue exhibits? Why is the default 100% mandatory supplemental? 5) If a plan is able to calculate an "effective risk score" for the ESRD population that reflects the "back-solved" risk scores if ESRD members were all paid on the same basis as other members (actual or expected revenue pmpm divided by the normalized bid), why can't we include the experience in the base period?	1) This is not the proper forum to propose changes to the Part D payment demonstration policies. We believe there is no oppotunity to change the requirements of the payment demonstration, as the policies are already established. 2) Please refer to Appendix B of the 2007 MA-PD Call Letter for guidance on rebate reallocation and premium rounding following the publication of the Part D national average monthly bid amount. As provided under Section III.B of this guidance, CMS does not expect, and will not allow, MA organizations to substantially redesign Part C supplemental benefits during this rebate reallocation period. Accordingly, any elimination of mandatory supplemental benefits must be consistent with this principle. If an organization removes a mandatory supplemental benefit during the rebate reallocation period, and the change is consistent with the rebate reallocation guidance, then they will be permitted to offer that exact benefit as an optional supplemental benefit. 3) This question potentially raises two issues: 1) Credibility of Experience: Plans have the option to combine base period experience as appropriate and ut 4) ESRD enrollees and experience are not included in the plan's "bid" or bencl 5) This is inconsistent with the bid instructions and CMS policy for CY2007.
10	MA - BPT	6/1/2006	5/24/2006 5:12 PM	Cost Sharing Information	We are bidding standard Medicare benefits for an MSHO plan (Minnesota Senior Health Options), and are wondering if in worksheet 3, column h we can type the words "Medicare Cost Sharing" for each row? There are up to four rows of descriptions, depending on day of service, for facility services which doesn't fit nicely on the bid form. Otherwise you would expect us to combine all of the description in one row?	Yes, plans may indicate "Medicare FFS Cost Sharing" as appropriate. The pricing assumptions on Worksheet 3 must support the development of FFS. The FFS assumption should be clearly labeled in the BPT. Plans can also upload supporting documentation to further describe the FFS pricing assumptions, as needed.
11	MA - BPT	6/1/2006	5/29/2006 6:02 PM	OACT Conference Call on 6/1	In 2006, we are receiving cost sharing reimbursement on behalf of a very small percentage of our SNP (dual eligible) members. In 2007 we are filing a separate SNP bid . Do we; a) Show this in our 2007 A/B SNP bids ? b) Where do we show these amount ?	Revenue from the State should be reflected in the bid filing in accordance with the CY2007 MA/MA-PD Call Letter. See page 19 of the MA/MA-PD CY2007 Call Letter regarding plans serving Qualified Medicare Beneficiaries (QMB): http://www.cms.hhs.gov/HealthPlansGenInfo/Downloads/REV%20MA-MAPD%20Call%20Letter%20Final.pdf
12	MA - BPT	6/1/2006	<call to Help Desk>	not available	Question about the BPT calculations for a Special Needs Plan: User is finding that if they reduce the cost sharing amounts to $0, the BPT then increases the member premiums to compensate. User does not believe these increased premiums are correct for SNP members. User is entering these $0 cost sharing amounts because of Marketing guidelines they received that informed them of a change for this year, allowing plans to display the 0 cost sharing information to members.	The BPT should reflect consistent cost sharing as entered in the PBP (whether that is zero cost sharing or FFS cost sharing or something else). The BPT allowed costs should be developed consistently with the BPT cost sharing assumptions. In reference to the marketing guidelines, this question has been forwarded to CBC (Jane Andrews and Marty Ablen).

Questions from actuarial-bids@cms.hhs.gov for OACT User Group Call (UGC)

#	Topic	UGC date	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS response
13	MA - 2YRLB	6/1/2006	5/26/2006 2:04 PM	Contract XXXX Organization Name: XXXX	On the HPMS website there is currently no 2-year lookback data for contract HXXXX. This contract is a demonstration SHMO project. It is our assumption, therefore, that we don't need to include information from this plan in our two year look back. Please confirm.	Organizations can download the CY05ACR data used in the 2YRLB from HPMS (under HPMS Home>Plan Bids>Bid Submission>CY2007>Download>2-Year Lookback Projection Data). If a plan **has** 2YRLB data in HPMS (at the above path), then they are **required** to upload a 2YRLB form with their bid.
14	MA - 2YRLB	6/1/2006	5/26/2006 11:30 PM	2-yr lookback instructions clarification	Could you please clarify the definitions of Net Medical Expenses [2] a) covered benefits [2] b) A/B Mandatory Supplemental Benefits and where we can find the 2005 numbers provide by CMS on the 2005 ACR?	See response to question above regarding the location of the 2YRLB data in HPMS. Regarding the two categories in question: the covered benefits category refers to the ACR Basic Benefits (that is, the sum of Medicare Covered and Additional Benefits), and the A/B Mand Suppl category refers to the ACR Mandatory Supplemental benefits.

On one of the weekly user group calls, OACT was asked to provide an example of bidding under the ROI approach.
The example below contains one set of assumptions, and all figures are for illustrative purposes only.

Medicare Advantage Return on Investment (ROI) Example

Assumptions	
Monthly revenue	$750.00
Annual revenue	$9,000.00
Marketing / sales (1% of annual revenue)	$90.00
RBC: auth. control level (11% of annual rev.)	$990.00
RBC: company level (300% of ACL)	$2,970.00
Investment yield rate	3.5%
Tax rate	39%

	End of month													
	0	1	2	3	4	5	6	7	8	9	10	11	12	Annual
Values common to all scenarios														
Revenue	$0.00	$750.00	$750.00	$750.00	$750.00	$750.00	$750.00	$750.00	$750.00	$750.00	$750.00	$750.00	$750.00	$9,000.00
Change in company-level RBC	$445.50	$356.40	$297.00	$207.90	$207.90	$207.90	$207.90	$207.90	$207.90	$207.90	$207.90	$207.90	($2,970.00)	$0.00
Company-level RBC balance	$445.50	$801.90	$1,098.90	$1,306.80	$1,514.70	$1,722.60	$1,930.50	$2,138.40	$2,346.30	$2,554.20	$2,762.10	$2,970.00	$0.00	n/a
Investment income on RBC	$0.00	$1.28	$2.30	$3.15	$3.75	$4.35	$4.95	$5.54	$6.14	$6.74	$7.33	$7.93	$8.53	$61.99
Scenario 1: 8% after-tax ROI														
Marketing / sales	($90.00)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	($90.00)
U/W margin 2.86%	$0.00	$21.45	$21.45	$21.45	$21.45	$21.45	$21.45	$21.45	$21.45	$21.45	$21.45	$21.45	$21.45	$257.40
Investment income on RBC	$0.00	$1.28	$2.30	$3.15	$3.75	$4.35	$4.95	$5.54	$6.14	$6.74	$7.33	$7.93	$8.53	$61.99
Less income taxes	$35.10	($8.86)	($9.26)	($9.60)	($9.83)	($10.06)	($10.29)	($10.53)	($10.76)	($10.99)	($11.23)	($11.46)	($11.69)	($89.46)
After tax income	($54.90)	$13.86	$14.49	$15.01	$15.37	$15.74	$16.10	$16.47	$16.83	$17.19	$17.56	$17.92	$18.29	$139.93
Change in RBC	$445.50	$356.40	$297.00	$207.90	$207.90	$207.90	$207.90	$207.90	$207.90	$207.90	$207.90	$207.90	($2,970.00)	$0.00
Undiscounted cash flow	($500.40)	($342.54)	($282.51)	($192.89)	($192.53)	($192.16)	($191.80)	($191.43)	($191.07)	($190.71)	($190.34)	($189.98)	$2,988.29	$139.93
Annualized ROI	8.0%													
Scenario 2: 10% after-tax ROI														
Marketing / sales	($90.00)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	($90.00)
U/W margin 3.46%	$0.00	$25.95	$25.95	$25.95	$25.95	$25.95	$25.95	$25.95	$25.95	$25.95	$25.95	$25.95	$25.95	$311.40
Investment income on RBC	$0.00	$1.28	$2.30	$3.15	$3.75	$4.35	$4.95	$5.54	$6.14	$6.74	$7.33	$7.93	$8.53	$61.99
Less income taxes	$35.10	($10.62)	($11.02)	($11.35)	($11.58)	($11.82)	($12.05)	($12.28)	($12.51)	($12.75)	($12.98)	($13.21)	($13.45)	($110.52)
After tax income	($54.90)	$16.61	$17.23	$17.75	$18.12	$18.48	$18.85	$19.21	$19.57	$19.94	$20.30	$20.67	$21.03	$172.87
Change in RBC	$445.50	$356.40	$297.00	$207.90	$207.90	$207.90	$207.90	$207.90	$207.90	$207.90	$207.90	$207.90	($2,970.00)	$0.00
Undiscounted cash flow	($500.40)	($339.79)	($279.77)	($190.15)	($189.78)	($189.42)	($189.05)	($188.69)	($188.33)	($187.96)	($187.60)	($187.23)	$2,991.03	$172.87
Annualized ROI	10.0%													

Notes
1. All assumptions are illustrative and represent hypothetical situation
2. Assumed pricing horizon of one year
3. Investment income limited to earnings on risk-based capital
4. Assumed build-up in RBC: 15% in beginning of month 1; 12% in month 2; 10% in month 3; 7% in months 4 - 12

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services
Center for Beneficiary Choices
Medicare Advantage Group

7500 Security Boulevard
Baltimore, Maryland 21244

Date: May 1, 2006

To: Medicare Advantage Organizations
Part C Plans Only

From: David A. Lewis, Acting Director, Medicare Advantage Group

Subject: Over-the-Counter Benefits

In the 2007 MA and MA-PD Call Letters issued on April 4, 2006 we stated that for calendar year 2007 we would provide clarifying language related to the interpretation of supplemental benefits and the inclusion of Over-the-Counter (OTC) benefits under Medicare Part C (see Section V. Benefit Design). This memorandum serves to provide that guidance.

As stated in the 2007 Call Letter, neither Part C of the Social Security Act - which governs the Medicare Advantage (MA) program - nor the implementing regulations at 42 CFR Part 422 specifically address coverage of OTC non-prescription drugs (such as Prilosec and Claritin) and health-related benefits (such as Band Aids).

For calendar year 2007, effective January 1, 2007, Part C Medicare Advantage Plans and Medicare Advantage – Prescription Drug (MA-PD) plans may cover OTC benefits as either a Mandatory supplemental benefit or an Optional supplemental benefit.

Mandatory supplemental benefits are Medicare Advantage plan and MA-PD plan benefits not covered by original Medicare that the MA enrollee must "purchase" as part of the MA plan. Mandatory supplemental benefits are paid for either in full, directly by, or on behalf of MA enrollees by premiums and cost sharing, or through the application of rebate dollars. Optional supplemental benefits are also benefits that are not covered by original Medicare. Plan enrollees may choose whether to elect and pay for optional supplemental benefits. MA organizations may offer individual items or groups of items and services as optional supplemental benefits. Rebate dollars may not be applied towards optional supplemental benefits. (See Chapter 4 of the Medicare Managed Care Manual – #100-16 for supplemental benefit guidelines as they apply to MSA plans.)

If you need additional information, please contact LaVern Ware at Lavern.Ware@cms.hhs.gov or by calling at 410-786-5480.

Question: Can Part D plans include over-the-counter products (OTCs) as part of administrative expenses since they may provide significant cost savings as part of a utilization management program?

Answer: CMS understands that health plans and pharmacy benefit managers currently provide targeted coverage of over-the-counter medications (OTCs) in the commercial market as part of their cost-reduction strategies. OTCs -- many of which (e.g. Prilosec OTC® and Claritin®) were available by prescription when first marketed -- offer significantly cheaper alternatives to branded prescription medications, and often work just as well for most patients. The MMA does not allow Medicare plans to include OTCs as part of their drug benefit or supplemental coverage. As an incremental extension of the 2006 policy, for the 2007 benefit coverage year, CMS will allow Medicare plans the option to provide this alternative as part of their administrative cost structure without limitation to approved step therapy protocols since other OTCs play a role by substituting for prescription drugs as part of an overall drug utilization management strategy (e.g. OTC non-steroidal anti-inflammatory drugs). Having the plan process OTC purchases at the pharmacy under the Part D contract improves safety by allowing the prescription drug plan to access and include information on OTC utilization in its drug utilization review editing.

CMS will continue to review and approve plans' specific OTC protocols shown to provide safe, effective and less costly alternatives. While the potential cost savings associated with using certain OTCs is significant, CMS does not believe many OTC products will offer such savings. In certain situations, OTCs may be included as part of a step-therapy program, but this is no longer required. However, if a plan includes OTC products as a part of its utilization management program other than within step-therapy algorithms, the plan may not prior authorize or otherwise limit dispensing of formulary alternatives on the basis of prior usage of the OTC product.

Without exception OTCs included as part of a cost-effective drug utilization management program must still be provided to the beneficiary without any direct cost-sharing at the point of sale (costs would be included in administrative portion of the bid and, thus, ultimately reflected in premiums).

As we stated in the 2006 OTC guidance, since CMS will limit OTCs to those shown to provide safe, effective and less costly alternatives to formulary drugs, and since plans are not obligated to include OTC products within their utilization management programs, Medicare beneficiaries should not expect broad inclusion of OTCs under the Part D benefit. Similarly, States should not interpret this as justification to discontinue coverage for OTCs under Medicaid Programs. Plans choosing to include OTC products within their utilization management programs must understand and be prepared to appropriately educate their enrollees on the difference between OTCs provided as administrative costs as opposed to covered part D drugs. While beneficiaries will (and must) enjoy zero direct cost-sharing on these OTCs, they will also not have the same beneficiary protections required to ensure appropriate access to part D drugs. For example, if a plan changes its utilization management program to substitute one OTC agent for another, beneficiaries would not have meaningful transition supplies or exceptions or appeals options to remain on the original OTC agent. (This does not affect enrollees' ability to pursue an exception or appeal of step therapy requirements in favor of a part D drug).

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Center for Beneficiary Choices
Medicare Plan Payment Group

Date: May 19, 2006

To: All Part D Plan Sponsors

From: Tom Hutchinson, Acting Director
Medicare Plan Payment Group

Subject: Q&A Addressing Drug Costs Reported On Prescription Drug Events (PDEs)

In response to questions concerning the reporting of drug costs on Prescription Drug Events (PDEs), CMS is releasing the attached Question and Answer (Q&A). This Q&A clarifies how drug costs must be reported on PDEs, particularly when a Part D Sponsor has contracted with a Pharmacy Benefit Manager (PBM) for administrative services. For the purposes of reinsurance and risk corridor payments, it is imperative that the appropriate drug costs are reported on PDEs. This Q&A provides guidance which should help Part D Sponsors ensure that they are reporting the correct amounts.

Further Information
If you have questions about this Q&A, please contact Meghan Elrington at (410) 786-8675.

Q&A

Question: When reporting Prescription Drug Event Data, may the Plan Sponsor report the amount it pays to the PBM or must it determine and report the amount the PBM pays to the pharmacy?

Answer: The Plan Sponsor is required to report the amount ultimately paid to the pharmacy – not the amount paid to the PBM. In fact, the amount ultimately paid to the pharmacy by either the Sponsor or PBM must always be the basis for (i) calculating beneficiary cost sharing; (ii) reporting drug costs on the Prescription Drug Event (PDE) records, and (iii) developing bids submitted to CMS.

The above policy is required by the statutory and regulatory definitions of "allowable reinsurance costs" and "allowable risk corridor costs," which in both cases exclude any administrative costs of the Sponsor (including administrative fees paid to a PBM). By statute, "allowable reinsurance costs" are a subset of "gross covered prescription drug costs," and Congress specifically defined such gross costs as "not including administrative costs." 1860D-15(b)(2) and (3). Similarly, Congress defined "allowable risk corridor costs" as "not including administrative costs." 1860D-15(e)(1)(B). Our regulations at 42 C.F.R. 423.308 adopted these definitions. Because the PDE records are used to calculate both reinsurance and risk corridor payments, it is imperative that the amounts reported on such records exclude administrative fees paid to the PBM. Thus, the Ingredient Cost, Dispensing Fee, Sales Tax, Gross Drug Cost below the Out of Pocket Threshold (GDCB), and Gross Drug Cost above the Out of Pocket Threshold (GDCA) fields should never include administrative fees paid to a PBM – but rather should always reflect the final amount ultimately received by the pharmacy at the point of sale.

In addition, beneficiary coinsurance must be based on the amount paid to the pharmacy. According to our regulations at 42 C.F.R. 423.104, beneficiaries pay their applicable cost sharing based on the "actual costs" for covered Part D drugs. "Actual cost" is defined in 42 C.F.R. 423.100 as "the negotiated price for a covered Part D drug when the drug is purchased at a network pharmacy, and the usual and customary price when a beneficiary purchases the drug at an out-of-network pharmacy." "Negotiated prices" are "prices for covered Part D drugs . . . that are available to beneficiaries at the point of sale at network pharmacies." Therefore, beneficiaries are not responsible for paying cost-sharing on the plan's administrative costs but solely on the actual amount paid for the drug (including any dispensing fee) to the pharmacy by the plan or the plan's subcontracted PBM. Part D Sponsors are expected to take measures to ensure that beneficiary coinsurance is based on the amount paid to the pharmacy – so that beneficiaries are not paying any amount based on the Sponsor's administrative fees to a PBM. In addition, the amount paid by the beneficiary should reflect any point-of-sale price concessions.

Also, when a Part D Sponsor contracts with a PBM that owns a mail-order pharmacy, the Sponsor must take special care that the PDE costs do not include administrative costs for PBM services. For example, the Ingredient Cost should not include any administrative costs, but should be an accurate reflection of the product purchased from the mail-order

pharmacy in terms of manufacturer, strength, and acquisition price. In addition, while the Dispensing Fee reported may include overhead costs for operating the mail-order pharmacy, the Fee should not reflect other administrative costs of the PBM (such as operating a call-center for the Sponsor's plan, contracting with network pharmacies, or negotiating rebates with manufacturers). We are also concerned that in cases where the PBM owns the mail order pharmacy, the ingredient cost and dispensing fees may not reflect the fair market value and therefore will monitor these prices.

We have become aware that in some instances, the PDE records being submitted to us reflect the amount paid by a Sponsor to a PBM, and not the amount ultimately received by the pharmacy. In these cases, we view the higher fee reported on the claim (whether such fee is included in the Ingredient Cost or Dispensing Fee element) as reflecting administrative fees (including any profit margin) paid by the Sponsor to the PBM for administrative services (e.g., network access, use of the switch, call center services, formulary management). Including such higher fees on the PDE record has the effect of improperly including administrative costs in the reported drug costs, in violation of 42 C.F.R. 423.308 and the cost sharing requirements of 42 C.F.R. 423.104.

Because both the regulations and the statute were clear that allowable reinsurance and risk-corridor costs must not include any administrative costs, our expectation was that Sponsors would structure their contracts with PBMs such that the drug prices reported on the PDE record reflect the price paid to the pharmacy. However, we understand that in rare instances, for the 2006 coverage year, some Part D Sponsors' contracts with PBMs did not identify administrative fees separately from drug cost, and did not specify that PDEs would reflect the price ultimately paid to the pharmacy. In these rare cases, where (a) the contract does not distinguish these two costs and (b) the PDEs reflect the prices paid to the PBM inclusive of administrative fees instead of to the pharmacy, we will allow Part D Sponsors to report an estimate of the administrative costs paid to the PBMs in the 2006 reconciliation process. CMS will use this estimate in determining Part D Sponsor's allowable costs for purposes of making final payment and reconciliation for the 2006 coverage year. These estimates may be subject to further audit by our program integrity division, as well as by the Office of the Inspector General.

For the 2007 coverage year, all Sponsors are required to take whatever actions are necessary to comply with the regulatory reporting requirements. On the PDE record, Part D Sponsors or entities submitting on the Sponsors' behalf must report the price paid to the pharmacy, net of direct and indirect remuneration (DIR) reflected in the price at point of sale and net of administrative costs. Part D Sponsors' are reminded that administrative fees and DIR dollars are not interchangeable at any point in the reporting or payment processes. Administrative fees and DIR must be separately identified by the Part D Sponsor when (i) estimating their bid costs; (ii) reporting drug costs on the PDE net of both administrative costs and DIR reflected in point-of-sale pricing; and (iii) reporting all other DIR to CMS after the end of each coverage year for determination of allowable costs in reconciliation.

When developing bids for 2007, Part D Sponsors must (i) estimate gross prescription drug costs that do not reflect any administration costs, (ii) separately identify 100% of the plan's administrative costs performed by the plan, or by the plan's subcontracted PBM, as administrative costs and (iii) categorize these costs consistent with the instructions for reporting administrative costs on the bid tool. When contract arrangements cannot be finalized before June 2006, plans may submit estimates of their best expectation for 2007 costs for purposes of completing the bid tool.

DEPARTMENT OF HEALTH & HUMAN SERVICES
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OFFICE OF THE ACTUARY

DATE: May 3, 2006

TO: Medicare Advantage (MA) Organizations and Actuaries

FROM: Solomon Mussey, Acting Director, Parts C&D Actuarial Group

SUBJECT: Revised CY 2007 Bid Instructions for Development of MA Risk Scores

In response to questions on acceptable techniques to develop risk scores for the CY 2007 MA bids, CMS has revised our bid pricing tool (BPT) instructions. The complete revised MA BPT instruction document is now posted on the bid submission documentation section of HMPS. Also, Appendix I to this memorandum contains the revised section of the instructions. Please note, that there are not corresponding changes to the CY 2007 Medicare Prescription Drug Plan BPT instructions.

Also, CMS will provide information on plan average scores under the new model for all existing MA and MA-PD plans with enrollment as of May 2006, using CY 2005 diagnoses (with run-out through 4/1/2006). These scores will be posted on HPMS for plans to access on Friday, May 5, 2006.

Appendix I

Revised MA BPT Instructions CY 2007
Worksheet 5, Section V

Column f – Non-ERSD Projected Risk Factor. Enter the risk factors for the projected non-ESRD membership by county. In accordance with Appendix B, supporting documentation for the development of the projected risk scores is required.

Changes to Risk Score Development for 2007
The goal of the risk score development is to develop a plan average risk score for the projected 2007 population. CMS has re-estimated the CMS-HCC risk model on which risk scores are determined for 2007; we refer to this re-estimated model as the "recalibrated" or "new" model. Because the CMS-HCC model has been recalibrated, the appropriate starting point to develop a projected 2007 risk score is a score calculated under the **new** CMS-HCC model. In order to facilitate the development of an appropriate 2007 score, CMS will provide information on plan average scores under the new model for all existing MA and MA-PD plans with enrollment as of May 2006, using CY 2005 diagnoses (with run-out through 4/1/2006).

Additionally, FFS normalization, a process which adjusts risk scores to a 1.000 average for each payment year, will be applied to risk scores calculated under the new model. FFS normalization of the risk scores produced by the model will take place prior to payment in 2007 and for subsequent years. The normalization factor that will be applied in 2007 is 1.029 (that is, risk scores will be divided by 1.029). In 2006, under the original CMS-HCC model, FFS normalization was incorporated into the benchmarks; thus no adjustment was made in the development of the risk scores.

Risk Score Development for New Plans
Acceptable approaches for the development of risk scores depends on whether or not the plan is new or exists currently. New plans (i.e. those plans not expected to enroll existing MA enrollees) should estimate risk scores based on the expected medical expenses for their projected enrollees. Further, the risk scores for new plans must be developed based on the new CMS-HCC model, which can be found at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/, under "risk adjustment".

Risk Score Development for Existing Plans
The preferred method for development of projected risk scores for existing plans is:

1. Use a plan average risk score computed under the new CMS-HCC model as the basis for risk score development. Plan average risk scores under the new model, computed by CMS, will be provided to existing MA and MA-PD organizations through HPMS. Organizations also have the option to calculate a risk scores for their enrollees using the 2007 CMS-HCC risk adjustment software available at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/06_Risk_adjustment.asp#TopOfPage. Organizations that calculate risk scores using the new model software must appropriately assign beneficiaries to the correct version of the model (community, institutional, or new

enrollee). New enrollees are defined as beneficiaries with less than 12 months of Medicare Part B enrollment in the data collection period. Organizations should make appropriate adjustments to account for incomplete diagnosis data for full-risk enrollees for whom they do not have 12 complete months of diagnostic data in the data collection period (i.e. those beneficiaries newly enrolled to the plan from FFS or from another MA organization) otherwise their average risk score will be underestimated for the projected population.

2. Adjust the new CMS-HCC risk scores as follows:
    a. Adjust for seasonality. CMS has consistently found that average plan risk scores decline throughout the payment year. Our research indicates the risk scores decline on average about 0.57% per month due to changes in the insured population; however, your plan's experience may vary and you should adjust accordingly. Typically, a plan's risk score is average for the year in the month of July. Therefore, a reasonable adjustment is to multiply your May risk score by 0.9886.
    b. Adjust for the impact of submitting diagnoses data after April 1, 2006 (i.e. late data). MA and MA-PD have approximately 12 months after the end of the data collection year to submit additional diagnostic data which impact their final risk score. Our experience shows that the average effect of data submitted after March of the contract year is to increase risk scores by 2.5%. Again, each plan's experience will vary and you should adjust your projected risk score accordingly.
    c. Adjust for projected change in risk score from 2006 to 2007. Plan risk scores may be projected to change between 2006 and 2007 for a variety of reasons, notably changes in the characteristics of the projected enrolled plan population and/or improvements in diagnostic data collection and submission. Plans should use their historical experience to project risk scores to 2007.
    d. Divide the 2007 plan projected risk score by the 2007 FFS normalization factor. The 2007 FFS normalization factor is 1.029. This step ensures that the projected risk score used to calculate the bid and benchmark is adjusted in the same manner as payments will be adjusted in 2007.

Example of Risk Score Development for Hypothetical Plan

	Base Score/ Adjustment	Adjusted Score for use in 2007 Bid	Comments
New CMS-HCC Risk Score (Enrollment as of May 2006 MMR)	1.00	1.00	Hypothetical Plan Risk Score under new CMS-HCC model using calendar year 2005 diagnoses data w/ run out through 4/1/2006
Seasonality Adjustment	1.00 * (1 - .0057)^2	.9886	Base risk score adjusted to July 2006 to reflect average plan score for calendar year 2006
Late Data Adjustment	.9886*1.025	1.0133	Adjustment for late data submitted after 4/1/2006 and prior to 1/31/2007
2006-2007 plan risk score change projection	1.0133*1.03	1.0437	Hypothetical adjustment for projected changes in the health status of the plan's enrollment between 2006 and 2007
FFS Normalization of 2007 projected plan risk score	1.0437/1.029	1.0143	Application of FFS normalization factor to the projected 2007 risk score

Notes: Adjustments for seasonality and late data are based on CMS data modeling, 2006-2007 plan risk score change adjustment projection is purely hypothetical, FFS normalization adjustment will be applied to payment in 2007.

Thus, the resulting risk score to be input into Worksheet 5, Section V, column f, of the 2007 MA bid pricing tool is 1.0143. Please note, that the above example would typically apply to individuals enrolled in all counties in the plan's service area.

Reminder: The new model risk scores released March 31, 2006 through HPMS, which were used for CMS' analysis of the impact of the new CMS-HCC model, are based on an earlier cohort (July 2005) and an earlier data collection period (CY 2004 diagnoses).

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PLAN OVERSIGHT & ACCOUNTABILITY GROUP

DATE: May 26, 2006

TO: All Medicare Advantage, Prescription Drug Plan, Cost, PACE, and Demonstration Organizations

FROM: Cynthia E. Moreno
Director

SUBJECT: REMINDER - CY 2007 Bid Upload Requirements

The Health Plan Management System (HPMS) Contract Year (CY) 2007 Bid Upload functionality was made available on May 19, 2006. Organizations are encouraged to begin completing the upload requirements that accompany the physical upload of the bid submission. The upload functionality and upload requirements cited in this document can be found by logging into the HPMS and selecting Plan Bids > Bid Submission > Contract Year 2007 > Upload. As has occurred in past years, if any of the required upload components are not completed by the June 5, 2006 bid submission deadline, the bid submission will not be sent forward to the desk review process.

The following is a complete listing of the 2007 upload requirements:

- Service Area Verification (new for CY 2007)
- Plan Crosswalk
- Formulary Crosswalk
- Actuarial Certification
- Two-Year Lookback Spreadsheet
- Bid Submission

Note: Some steps may not be required for every organization/plan.

The sections below describe each upload requirement in greater detail. Please pay special attention to which organizations/plans are bound by each upload requirement.

Service Area Verification

The Service Area Verification step is an upload requirement for all organizations/plans that must be complete by COB Tuesday, May 30, 2006. This will allow CMS to correct the service area as needed prior to the Bid submission deadline.

The Service Area Verification function requires organizations to review their entire contract service area and applicable attributes (e.g. employer-only/pending/partial counties or regions) and provide concurrence or non-concurrence. As long as organizations concur OR non-concur, the service area verification requirement will be considered complete for the purposes of the upload process. However, organizations that non-concur must provide an explanation as to what is incorrect in HPMS and then resolve the differences with CMS in a prompt and timely fashion. Once resolution is met with CMS, organizations must re-verify the service area and ultimately concur.

For organizations with pending CY 2007 applications, the Service Area Verification step is not to be used to add additional counties that were not part of the application provided on March 20, 2006. Furthermore, if no application was provided in March 20, 2006, then no counties may be added during the verification process. In early June, CMS intends to issue conditional approval letters and/or intent to deny letters to pending CY 2007 applicants based on CMS review. These letters will not reflect any changes made during the service area verification process because of the timing of the verification. To the extent the application review results are affected by changes made during the verification process, then the CMS finding of conditional approval or intent to deny could change.

Plan Crosswalk

The Plan Crosswalk step is an upload requirement for Renewal Contracts (i.e. contracts that existed in CY 2006).

The Plan Crosswalk function requires organizations to identify the relationships between their approved CY 2006 plans and proposed CY 2007 plans. CMS uses the plan crosswalk to identify whether plan rollovers are required for the upcoming contract year due to a plan reconfiguration as well as to identify beneficiary notification requirements.

Formulary Crosswalk

The Formulary Crosswalk step is an upload requirement for all contracts that submitted a formulary to HPMS.

The Formulary Crosswalk function requires organizations to map each Part D plan to a formulary. One formulary may be mapped to one or more plans. In order for this requirement to be considered complete, all plans offering Part D under the contract number that submitted the formulary must be associated with a formulary ID AND all formularies submitted by an organization must be assigned to a plan.

Actuarial Certification

The Actuarial Certification step is an upload requirement for all contracts submitting an MA BPT, Part D (Rx) BPT, or MSA BPT to HPMS.

Organizations are required to upload an initial Actuarial Certification to certify the BPT submission. For 2007, the Actuarial Certification upload functionality is now part of the Substantiation upload. One Actuarial Certification may be submitted for one or more contracts/plan/segments. Additionally, one Actuarial Certification may be submitted for the MA BPT and Part D (Rx) BPT for Medicare Advantage organizations offering Part D. Filenames should be in the following format: filename_date.ext. The Actuarial Certification upload file may include the following formats: ZIP, TXT, DOC, XLS, JPG, GIF, and PDF.

Two-Year Lookback Spreadsheet

The Two-Year Lookback spreadsheet is an upload requirement for certain MA Renewal Contracts. Organizations will be able to determine whether the Two-Year Lookback spreadsheet upload is required for their organization by reviewing the Upload 2-Year Lookback status screen in the HPMS by going to Plan Bids > Bid Submission > Contract Year 2007 > Upload > 2-Year Lookback. If the contract number/name is listed in the grid, then a Two-Year Lookback spreadsheet is required.

Organizations are required to upload the completed Two-Year Lookback spreadsheet. This upload is at the contract level and is separate from the bid submission.

Bid Submission

The Bid Submission step is an upload requirement for all organizations/plans.

Organizations are required to upload the completed Bid Submission, which is comprised of the applicable BPT(s) and PBP for each plan being submitted. Organizations should ensure that all patches have been applied to the BPT and PBP prior to upload.

Throughout the bid submission process, organizations should review the status of the various components of the Bid Submission Upload to ensure completion. This can be viewed by going to HPMS and selecting Plan Bids > Bid Submission > Contract Year 2007 > Upload > Review Upload Status.

For questions about this process, please contact the HPMS Help Desk at either 1-800-220-2028 or HPMS@cms.hhs.gov or Kristin Finch at either 410-786-2873 or Kristin.Finch@cms.hhs.gov. Thank you.

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Center for Beneficiary Services

DATE: May 25, 2006

TO: All Medicare Advantage Organizations, Prescription Drug Plan Sponsors, Section 1876 Cost-Based Contractors, and Employer/Union Direct Contractors

FROM: Brenda Tranchida, Deputy Director
Employer Policy and Operations Group

SUBJECT: Employer/Union-Only Group Waiver Plan (EGWP) Service Area and Bidding Requirements - REMINDER

This is a reminder that for Contract Year (CY) 2007, all entities offering employer/union-only group waiver plans (EGWPs) must submit bids by the June 5, 2006 deadline. This includes all employers and unions that contract directly with CMS to offer these plans to their members and Prescription Drug Plans, Medicare Advantage Organizations and Section 1876 Cost-Based Contractors that offer these plans to employer and union groups.

All entities will be subject to the same basic bidding and payment rules that were applied to these plans in CY 2006. We have highlighted several important reminders related to the submission of bids for these plans which are set forth below:

Private Fee-For-Service Medicare Advantage Plans and Stand-alone Prescription Drug Plans:

For Contract Year (CY) 2006, CMS granted service area extension waivers to all non-network Private Fee-For-Service (PFFS) plans (both MA-Only plans and MA-PDs) and Prescription Drug Plans (PDPs) that offer EGWPs. CMS extended these waivers for the 2007 contract year, which will allow these kinds of plans to cover employer and union group members nationwide if entities meet the requirements of the waiver. The waivers apply when the most substantial portion of the employer's employees (or in the case of a union, its participants) reside in a state or PDP region where the PFFS plan or PDP is also a provider of non-group coverage. For more details on these waivers, please refer to our website: http://www.cms.hhs.gov/empgrpwaivers.

To be able to utilize this waiver during CY 2007, a non-network PFFS plan or PDP must have a designated national service area and submit a "national" Part C and/or Part D bid. Please note that these plans will not be required to have pharmacy networks in place until they contract with an employer or union group that has members who reside in the extended service areas. **Also please note that for CY 2007, as in CY 2006, no mid-year service area expansions will be permitted for EGWPs. Entities that fail to request a "national" service area and to submit a corresponding national bid will not be able to utilize these waivers to cover EGWP members nationwide.**

Medicare Advantage (MA) Bids:

For CY 2007, entities offering EGWPs have a choice of whether to use a fee-for-service or composite bidding approach. More specifically, the cost sharing priced in worksheet 3 of the Bid Pricing Tool (BPT) must correspond to that contained in the Plan Benefit Package (PBP). The PBP can either be prepared using the expected composite benefit plan or may be based on the Medicare fee-for-service benefit provisions.

MA bids cannot reflect an allocation of A/B rebates to buy down Part D basic premium or Part D supplemental premium. Even though this kind of specific allocation is prohibited in the bid, MA Organizations retain the flexibility to allocate rebates to buy down Part D basic premium or Part D supplemental premium on an individual employer/union basis for each PBP.

Part D Bids

All Part D bids are based on Defined Standard coverage with no supplemental benefits included in the bid.

Each employer/union-only group bid must reflect the composite characteristics of the individuals expected to enroll in the plan in CY2007.

For more comprehensive and specific employer/union-only group waiver bidding instructions, please refer to: Instructions for Completing the Medicare Advantage Bid Pricing Tool For Contract Year 2007 (Appendix D – Medicare Advantage Products Available to Groups) (May 1, 2006) and Instructions for Completing The Medicare Prescription Drug Plan Bid Form for Contract Year 2007 (Worksheet V, Appendix D - Employer/Union-Only Group Requirements) (April 5, 2006). *Also see* CY 2007 "Call Letters" - PDP Instructions for 2007 Contract Year, Section XIV (April 4, 2006) and MA, MA-PD CY 2007 Instructions, Section XIII (April 4, 2006).

If you have any questions concerning these requirements, please contact Sara Walters at (410) 786-3330 or at Sara.Walters@cms.hhs.gov or Julian Nadolny at (410) 786-2274 or at Julian.Nadolny@cms.hhs.gov.

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Center for Beneficiary Choices
Medicare Plan Payment Group

Date: May 26, 2006

To: All Part D Plan Sponsors

From: Abby L. Block, Director
Center for Beneficiary Choices

Subject: LIS Benchmark Calculations

CMS has received inquiries concerning the 2007 calculation of the regional low-income benchmark amount used to determine the low-income subsidy. We are currently considering an option that will allow benchmarks to be calculated in a manner that will further limit any facilitated changes in LIS beneficiary enrollment. Plans should be preparing bids that can be uploaded quickly should this option regarding LIS benchmarks be adopted. CMS appreciates the efforts of Part D Sponsors to remain flexible in their bid preparation to assure the best possible coverage for our LIS-enrolled beneficiaries.

Further Information
If you have questions, please contact Meghan Elrington at (410) 786-8675.